Department of Veterans Affairs

Office of Inspector General

COMBINED ASSESSMENT PROGRAM REVIEW

EDWARD HINES, JR. VA HOSPITAL HINES, IL

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Executive Summary

Combined Assessment Program Review of the Edward Hines, Jr. VA Hospital, Hines, Illinois

1. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Department of Veterans Affairs Edward Hines, Jr. VA Hospital (VAH), Hines, IL. The purpose of the review was to evaluate selected operations, focusing on the quality of management controls.

2. VAH Hines is a tertiary care facility, providing a full range of medical, surgical, and psychiatric services. As of July 1999, the hospital had 621 beds including 75 medicine, 38 surgery, 150 psychiatry and substance abuse, 68 spinal cord injury, 17 rehabilitation medicine, 34 blind rehabilitation, 29 intermediate medicine, and 210 nursing home care beds. Plans are underway to reduce inpatient acute psychiatry beds. Besides outpatient facilities at Hines, the hospital also operates six community based outpatient clinics (CBOCs). These are in Aurora, Elgin, Joliet, LaSalle, Manteno, and Oak Park, IL. The hospital is part of Veterans Health Administration Veterans Integrated Service Network 12. Its major affiliation is with Loyola University School of Medicine. The following table shows key workload indicators for the last 6 years.

Fiscal Year	Medical Care Beds	Unique Patients	Outpatient Visits	FTEE[1]	Medical Care Budget
1994	782	31,941	279,908	3,000	$207,770,350
1995	755	32,437	299,777	2,948	$218,520,751
1996	717	31,907	327,055	2,909	$219,163,332
1997	429	33,276	349,729	2,630	$219,253,892
1998	390	34,043	372,045	2,384	$206,601,325
1999	411[2]	31,382[2]	277,376[2]	2,264[2]	$207,476,539

1. Cumulative full time equivalent employees 2. As of June 30,1999

3. The OIG CAP team visited VAH Hines from July 12 to 16, 1999. The Appendices to this report contain the results of our limited testing of quality of care and management controls. The following areas appeared vulnerable and in need of greater management attention:

- Quality Program Assistance (QPA) - The medical care review identified several issues that required management attention. These include:

- Adjust the professional mix and staffing levels of Nursing Service employees assigned to patient care areas.
- Only one employee is on duty during a shift to staff both residential treatment wards (4 North and 4 South). The adequacy of this needs to be assessed.
- Assess the professional mix of primary care providers and consider increasing the number of nurse practitioners and physician assistants.
- Assess the closure of the radiology section in the Ambulatory Care Center and provide a better mechanism for transporting patients to Radiology and other services.
- Reduce the waiting times for patients receiving prescriptions.
- Evaluate registration areas that do not ensure auditory privacy and take corrective actions.
- Evaluate management's use and the equability of available awards to its employees.

- Management Control Issues - A number of areas were identified in which management controls should be strengthened:

  - Unannounced narcotics inspection procedures, drug destruction procedures, and pharmacy security can be improved.
  - Equipment items stored in the warehouse should be installed.
  - Surgeon productivity needs to be improved.
  - More staff should be devoted to Decision Support System implementation.
  - Patient bills should be accurately coded.
  - Controls over Government Purchase Cards can be strengthened.
  - Controls over part-time physician timekeeping can be improved.
  - Patients' agreement to pay copayments should be obtained.
  - The amount of Agent Cashier funds and Personal Funds of Patient's lost to theft needs to be determined.

We also reviewed 10 complaints to the OIG Hotline. (Two issues raised in these complaints bore no direct connection to VAH Hines and will be reported separately.)

- Office of Investigations Fraud and Integrity Awareness Briefings - These briefings discussed issues concerning the recognition of fraudulent situations, referral to the Office of Investigations, and the type of information needed to make a complaint referral.

4. In the Appendices to the report, we made a series of observations and recommendations that we believe warrant management attention. The Office of Inspector General may follow-up at a later date on corrective actions taken.

(Original signed by:)
RICHARD J. GRIFFIN
Inspector General

Combined Assessment Program Description

The Combined Assessment Program (CAP) combines the skills and abilities of the Office of Inspector General's (OIG) major components to provide collaborative assessments of Department of Veterans Affairs (VA) medical facilities. The OIG team consists of representatives from the Offices of Investigations, Audit, and Healthcare Inspections. They will provide an independent and objective assessment of key operations and programs at VA hospitals on a cyclical basis.

During the CAP review process, a special agent from the Office of Investigations conducts a Fraud and Integrity Awareness Briefing. The purpose of this briefing is to provide key staff of the hospital with insight into the types of fraudulent activities that can occur in VA programs. The briefing includes an overview and case specific examples of fraud affecting healthcare procurements, false claims, conflict of interest, bribery, and illegal gratuities. Office of Investigations personnel will also investigate certain matters that have been referred to the OIG by VA employees, members of Congress, veterans, and others.

Representatives from the Office of Audit conduct a limited review to ensure that management controls are in place and are working effectively. These auditors assess key areas of concern which will be derived from a concentrated and continuing analysis of Veterans Health Administration (VHA), Veterans Integrated Service Network (VISN), and VHA hospital databases and management information. These areas may include patient management, credentialing and privileging, agent cashier activities, data integrity, and the Medical Care Collections Fund.

Representatives from the Office of Healthcare Inspections (OHI) conduct a Quality Program Assistance (QPA) review. These are proactive reviews that incorporate the use of standardized survey instruments to evaluate the quality of care provided in VA healthcare facilities. OHI staff evaluates these facilities to determine the extent to which they are contributing to VHA's ability to accomplish its mission of providing high quality healthcare, improved patient access to care, and high patient satisfaction.

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Quality Program Assistance Review

Objective and Scope

The Quality Program Assistance (QPA) inspection provides a balanced perspective of Veterans Affairs Medical Center's ability to provide safe, effective patient care to the greatest possible number of eligible veterans. The QPA inspection uses structured survey instruments to assess the adequacy and efficiency of key operating elements and their ability to provide or support health care delivery.

During the QPA, OHI inspectors reviewed numerous quality assurance documents and 40 medical records, and inspected the entire system's outpatient and inpatient treatment facilities. Inspectors interviewed executive managers, 20 clinical managers, 52 clinicians, and 126 patients. OHI distributed questionnaires to 657 full-time employees whom we randomly selected from the system's staffing roster. The questionnaire return rate was 47 percent. We also interviewed several patients and employees who wished to voice their concerns regarding patient care.

The QPA review was done in accordance with the Quality Standards for Inspections published by the President's Council on Integrity and Efficiency.

Results

Executive Management Planning and Oversight

The Edward Hines, Jr. Veterans Affairs Hospital (VAH) is a tertiary care referral center located 12 miles west of downtown Chicago. It is a regional referral center for spinal cord injury treatment, blind rehabilitation, and radiation therapy. The Hospital top management team at Hines consists of the Director, the Interim Chief of Staff (COS), the Associate Director (AD), and the Acting Nurse Executive (ANE).

The Hospital Director in his interview with OHI inspectors confirmed that he is involved in activities that are designed to facilitate communication with employees and stakeholders. He convenes town meetings each quarter, with two such meetings on each of the three tours of duty. The hospital closed-circuit video system televises these town meetings so that all employees, patients, and visitors are afforded an opportunity to see and listen to the discussions. The Director has varied the format of these town meetings in an effort to maintain audience attention and interest. The variation is also done to ensure maximum opportunity for attendees to ask any and all questions that they believe are germane to everyone's interests about the ongoing or contemplated reorganization actions. The Director also poses and answers questions on the hospital's Intranet. Every

employee has an e-mail account, and each has ready access to ask questions, or to read the information that the Director and other managers provide in this medium. The Director also asserted, and interviews confirmed, that he frequently attends service staff meetings in which he invites any questions or remarks that attendees may have.

The Hospital Director strongly believes that he needs to regularly visit all areas of the hospital in order to personally view and understand what is going on in the organization, and to be visible to employees and patients in order to help instill and maintain organizational confidence.

The Director actively solicits input from Veterans Service Officers about issues that concern them and their constituent organization members. He also asks for Service Officers' feedback on proposed improvements or selected organizational changes before they occur. For example, the Director invited the Paralyzed Veterans of America (PVA) to review, comment on, and offer design revisions for the renovated Canteen Dining Room. The PVA's input resulted in the dining room being more accessible to wheelchair-bound and other handicapped patients and employees. He also invited Service Officer input before making parking lot improvements, and the resulting advice resulted in a design that ensures better parking access to handicapped patients, visitors, and employees.

Performance Improvement Initiatives

The Director and his top managers are proud of the process improvement initiatives that they have engaged in during the past year. They believe that these initiatives have improved patient care, patient satisfaction, and have also reduced overall costs for treating patients. The Director cited the evolution of most cancer chemotherapy procedures from the inpatient setting to ambulatory care, and a greatly improved discharge planning process that results in more appropriate patient post-institutional placements. These initiatives improve care by reducing patients' lengths-of-stay, and afford patients the opportunity to have a greater degree of control over their treatment process.

The hospital is also aggressively pursuing implementation of the computerized patient record system (CPRS). The Director estimated that the hospital has reached about the half-way point in fully implementing an electronic automated medical record, and he stated that clinicians are already praising the system, while expressing their desire to reach full implementation as quickly as possible. He also cited the fact that clinicians in the Blind Rehabilitation Center virtually abandoned 35 to 40-day treatment programs, and they now tailor blind rehabilitation to meet the needs of each patient. This initiative not only reduced the average length-of-stay for patients who need blind rehabilitation, but it also substantially improved patient and employee satisfaction with the program.

Other new initiatives planned are the delivery of services in the outpatient clinics located in Manteno, Oak Park, Elgin, Aurora, Joliet, and LaSalle/Peru, Illinois. Additionally, managers are in the process of establishing a new clinic in the Oak Lawn area. Also, new initiatives include the development of a Women's Health Clinic, a daytime telephone liaison program, and a Substance Abuse Residential Rehabilitation and Treatment Program.

The Director told us that in the coming year, he plans to strengthen utilization review of inpatient stays for patients who are electively admitted to the hospital. The Utilization Management Program already reviews non-elective admissions. He asserted that this has led to reduced average lengths-of-stays, and caused several diagnostic categories' lengths-of-stay to be lower than those for private sector facilities that are reported by the Health Care Financing Administration.

The Director also plans to require clinical managers to examine the cost of pharmaceuticals, particularly high-cost drugs. He indicated that Pharmacy Service employees are already exploring the use of pill splitters for patients who can use the equipment. This will reduce the cost of some of the more costly medications that may be more expensive in lower dose multiples than in higher dose tablets that can be readily divided in half.

Staffing Issues and Impact of Budget Constraints

The Director and most of his top managers expressed their concern that funding constraints have reached a point at which patient safety, in some treatment areas, may be severely compromised. However, the Director acknowledged that he could not point to any specific incidents in which patients have suffered harm because of inadequate resources.

During fiscal years (FY) 1996 through FY 1999, hospital managers reduced total operating beds from 883 beds to the current level of 621 beds. During the same period, the number of physicians decreased from 155 to 138 full-time equivalent employees (FTEE). Nursing Service also experienced deep cuts in FTEE, from 913 in FY 1996 to the current level of 651 (a reduction of 263 FTEE). As of May 1999, the hospital had a total authorized FTEE level of 2,247, down from a total of 2,883 FTEE in FY 1996. Of the 2,247 current FTEE, 421 are registered nurses (RN's) and 138 are physicians.

Nursing employees told us that they currently have an Acting Nurse Executive in charge of Nursing Service. Employees felt that Nursing Service would be a more cohesive working group if that position were filled with a permanent employee. Nursing employees told us that the Acting Nurse Executive is aware of the staffing shortage and is under the same budget constraints as other service chiefs at Hines.

The Director reiterated to OHI inspectors that Nursing Service managers have had difficulty recruiting license practical nurses (LPNs) and nursing assistants because of the competing job opportunities available to them in the Chicago area. As of July 16, 1999, the hospital had a ceiling of 191 LPNs, with 27 vacancies. The Director informed OHI inspectors that according to area salary rates, the VA is still below the community average for salaries. The Director requested and obtained special salary rates for the LPNs, but many of these positions have been vacant in excess of 6 months. The staffing success rates in filling positions have been less than 50 percent.

In addition, many clinical managers, physicians, and nursing employees feel pressured about their workloads or, more significantly that, their ability to care for patients is being compromised by staff shortages. Examples of staff shortages exist in the extended care unit and spinal cord injury unit. A hospital review of those units' staffing coverage revealed that they could no longer provide quality of care without limiting admissions to both units. Consequently, both units now have limited admissions. Managers are aware of the limited admission policy and staff coverage on both units.

Nurse Staffing Distribution and Mix

As of July 6, 1999, about 62 percent of Nursing Service employees are RNs. On average, 2.3 RNs supervise each health technician or LPN. This ratio suggests high RN staffing levels and may need review.

Also, the data in the following below demonstrates that Nursing Service has many employees who do not provide actual hands-on patient care. For example, over 11 percent of Nursing Service employees are administrative personnel who do not provide direct care.

Distribution of Nursing Personnel

as of July6, 1999

POSITIONS AND TITLE	NUMBER OF EMPLOYEES (FTEE)	PERCENTAGE IN NURSING SERVICE
Administration Personnel	73.6	11.3%
Clerical Personnel	7.2	1.1%
LPN & LVN	135.4	20.8%
Nursing Aide & Assistant	33.8	5.2%
Registered Nurse	401	61.6%

Availability of Clinical Staff to Patients

Of the outpatients whom we interviewed, less than 10 percent (6/68) told us that they believed that there are not enough employees to meet their medical needs and answer their questions most of the time. In contrast, 56 percent of employees (162/289) who responded to the OHI employee satisfaction survey either strongly disagree or disagree that there is sufficient staff in their area to provide care to all patients who need it. Therefore, while most patients perceived that there are enough hospital employees to meet their needs, hospital employees feel otherwise. This is an area that warrants management attention.

Surgical and Anesthesiology Services

Clinical managers and clinicians interviewed in Surgical and Anesthesiology Services told OHI inspectors that reduced staffing levels have negatively affected the care provided by their services. They told inspectors that they are only able to operate six of the nine operating room suites because there are not enough nurses, anesthesiologists, and certified nurse anesthetists (CRNA). This condition has resulted in delayed or cancelled surgical procedures, or rescheduling surgical cases for evenings. Also, each anesthesiology clinician has to be on call eight or nine times per month.

Mental Health & Behavioral Service

Mental Health managers, clinicians, and patients we interviewed told us that there is a significant shortage of employees (particularly nursing employees) on the inpatient mental health wards. They are particularly concerned about the nurse staffing levels on the evening and night tours of duty, and specifically on the two residential treatment wards. One nursing assistant (called a concierge) is the only employee assigned to cover both of the residential treatment wards (4 North and 4 South) after hours. All of the clinical managers and clinicians interviewed in mental health and behavioral sciences areas told OHI inspectors that they believed that staffing the two units after hours with just one nursing assistant was potentially dangerous to both patients and the employees.

Other issues raised by mental health managers and clinicians centered on the downsizing of the number of disciplines that make up the interdisciplinary treatment teams in the mental health treatment programs. Because of staff reductions during the past 3 years, treatment programs have fewer group and individual therapy options available for patients. Nurse managers who we interviewed told OHI inspectors that they are unable to initiate any significant performance improvement measures because of inadequate staffing. One nurse told inspectors that employees are taxed to their limit in providing basic care to patients.

Another issue raised by mental health managers and clinicians on the mental health units is the impact of the introduction of the computerized patient record system (CPRS) and the amount of time involved. Most clinicians, while acknowledging the benefits of having an accessible and comprehensive electronic record, are concerned with the amount of time needed to enter required information into the electronic medical record. Clinicians feel this is taking away a significant amount of time that should be devoted to direct patient care.

Nutrition and Food Service

The Chief of Nutrition and Food Service advised OHI inspectors that the decreased length of stay in the hospital, as well as the loss of nine registered dietician (RD) FTEE, are making it difficult to ensure each admitted patient is screened in a timely manner. The service's current standard is to provide each admitted patient a nutritional assessment within 48 hours of admission to the hospital. Nutrition managers told OHI inspectors that they often cannot meet the screening standard.

Primary Care Providers

As stated above, the physician staff has decreased from 155 to 138 FTEE. With the current budget restraints, managers should assess the staffing mix of primary care providers to ensure maximum coverage. Increasing the number of nurse practitioners and physician assistants could allow the facility to increase the number of primary care providers without increasing costs.

Physical Access to Ambulatory Care Services

While on site, patients who requested to be interviewed reported to OHI inspectors that the radiology section in the Ambulatory Care Center was being closed because of inadequate staffing. This negatively affects patients seeking outpatient radiological services. Also, the patients complained to OHI inspectors that they must walk considerable distances for x-rays and other special procedures.

CLINICAL MANAGER, CLINICIAN AND PATIENT SURVEY RESULTS

General Interview Responses

Clinical employees and patients generally told us that:

- Patients are very pleased with the care they receive;
- The facility is usually clean;

- Employees are courteous;
- Patients can identify their primary care provider; and
- Patients are involved in treatment decisions.

Areas identified as needing improvement are:

- Pharmacy waiting times;
- Auditory privacy in registration areas;
- Radiology services in ambulatory care;
- Professional staff mix; and
- Morale of staff.

Waiting Times for Prescriptions and Special Procedures Need Improvement

About 58 percent of responding clinicians (25/43) and 63 percent of clinical managers (10/16) told OHI interviewers that outpatient prescriptions are not available from the pharmacy within 60 minutes. Also, patients told us that they frequently must wait up to 2 hours to pick up their medications. Compounding the timeliness of prescription availability is the distance that patients must walk to the outpatient pharmacy, about which patients complained to OHI inspectors. The outpatient pharmacy is almost ½ mile from the Ambulatory Care Center area. This long distance creates potential hardship and could be unsafe for patients, particularly if patients are elderly, handicapped or have respiratory problems.

Executive managers indicated that they are aware of the need to redesign both the ambulatory care areas and the pharmacies. Most outpatient clinics are located in the middle of a 2000-foot long building, with other clinics in an adjacent 15-story bed tower. Plans are now in progress to relocate the ambulatory care clinics and pharmacy to the main tower building. The redesign will begin during the first quarter of the FY 2000. The third and fourth floors of the tower building will contain ambulatory care clinics, and the outpatient pharmacy will be located on the first floor. Redesign of the ambulatory care clinics will greatly enhance the ability of patients to efficiently access ambulatory services.

Also, signage that guides patients from the Ambulatory Care Center to the outpatient pharmacy is confusing. Managers indicated that they are aware of these problems and told OHI inspectors that corrective actions have already been taken in the renovation plans. The redesign of clinics and the pharmacy in the tower building will make patient care and pharmacy service more efficient, and signage will be improved.

Access to Outpatient Care and Appointments

The hospital's outpatient care growth rate is posing a significant challenge to employees. Clinical managers and clinicians told inspectors that waiting times for scheduled appointments in primary care clinics and specialty clinics are excessive and need improvement. Only about 30 percent (14/43) of responding clinicians and 40 percent (6/15) of responding clinical managers indicated that patients can schedule a non-urgent appointment with their primary care provider within 7 days. In addition, only about 20 percent (9/44) of reporting Clinicians and 25 percent (4/16) of responding clinical managers indicated that appointments with specialists are available within 30 days of referral. Access to outpatient care services needs considerable improvement.

During FY 1999, eight outpatient specialty clinics had waiting times greater than 30 days, while other clinics had waiting times of at least 3½ months for the next available new patient appointments. The clinics with the most excessive waiting times were Arthritis, Cardiology, Diabetic, Endocrine, Geriatric, General Medical Clinic, Neurology, and Pulmonary.

Long Term Care Services

As discussed earlier, the extended care and spinal cord injury units were examples of units with reported staff shortages. Because of their staff shortage, both units have cross-trained employees who were reassigned from other units in the hospital. Managers told inspectors that several cross-trained employees have experienced on-the-job injuries. This has further aggravated the units' staffing shortage condition. While OHI inspected these units, a clinical manager told OHI inspectors that they were hiring contract-nursing assistants to help alleviate the staff situation, and additional hires were planned.

Leadership Preparation

About 66 percent (30/45) of responding clinicians we interviewed said that they are not aware of any facility training for preparing employees for leadership roles. In contrast, nearly 63 percent (10/16) of responding clinical managers were aware of a leadership preparation program.

Employee Questionnaire Results

Nearly all employees (98 percent or 299/304 employees) who responded to the confidential OHI questionnaire indicated that they believe they are qualified to do their jobs. Also, over 90 percent (275/305) agreed or strongly agreed that, directly or indirectly, their jobs contribute to improving patient satisfaction. More than 61 percent (188/305) of responding employees agree or strongly agree that, most of the time, they have manageable workloads.

More than 50 percent (162/305) of responding employees either agreed or strongly agreed that they could not be totally efficient because of inadequate resources. In addition, more than 50 percent (162/289) of responding employees agreed or strongly agreed that there is not enough staff to provide care to all patients.

Nearly 50 percent of responding employees (151/306) either agreed or strongly agreed with the statement that incompetence is encouraged and rewarded at VAMC Hines and 55 percent (167/306) disagreed or strongly disagreed that recognition and awards adequately reflect performance. More than 50 percent (153/304) of responding employees felt quality of care was a source of job satisfaction for them. In addition, 33 percent (142/307) of responding employees either agree or strongly agree that they would recommend treatment at the hospital to a family member or friend

Physical Plant Tour

OHI inspectors toured the following hospital areas: Ambulatory Care Center; all inpatient units; the spinal cord injury, acute psychiatric and intensive care units; and the pharmacies. During these inspections, OHI inspectors found that the patient and public bathrooms were clean, wheelchair accessible, and were adequately stocked with paper towels, toilet paper, and soap. We found the 11 areas to be generally clean and odor-free.

OHI inspectors found confusing signage in 7 of the total of 11 areas inspected. Additionally, the support services (x-ray, lab, and pharmacy) are not easily accessible for clinic patients.

In reviewing six of the hospital registration areas, OHI inspections found that five of these areas did not ensure patient privacy. Also, names and telephones numbers of the Patient Representative, the Equal Employment Officer, and the OIG's Hotline are not always visible in all of the patient care areas we inspected.

Employees told OHI inspectors that availability of wheelchairs at the hospital Information desk was insufficient at times, due to increased numbers of requests from patients. Also, there is inadequate employee coverage of the facility's information desk. For example, two employees are to cover the information desk. One employee works the

day tour while the other employee works the evening tour. These information desk employees are also to be assisted by volunteers and employee escorts to transport patients by wheelchairs throughout the hospital. However, when the evening shift employee is on leave, there is no one to help them locate additional wheelchairs to have available for the next day tour. This can cause patients to have to wait for wheelchairs and escorts at the information desk.

About 44 percent (37/50) of clinicians and 42 percent (12/19) of clinical managers felt that patients complain about the cleanliness of the hospital.

Patient Satisfaction

Generally, the patients indicated that they are satisfied with the quality of care that they receive at the hospital. About 90 percent (99/110) of the patients rated the overall quality of care that they receive as good to excellent. Also, over 90 percent (95/104) of the patients indicated that if they could go to any hospital, they would prefer to return to the Hines facility all or most of the time. And, 71 percent (71/100) of the responding patients told us that they would recommend medical care at this facility to a family member or friend all or most of the time.

All of the 20 clinical managers we interviewed rated the quality of care provided to patients as good to very good. In addition, 84 percent (43/51) clinicians rated the quality of care as good to excellent. Sixty-five percent (13/20) of the clinical manager respondents told us they would recommend care at this facility to a family member or friend, but only forty-nine percent (25/51) of the clinician respondents told us that they would recommend care at this facility to a family member or friend.

QUALITY MANAGEMENT ISSUES

Medical Record Review

OHI inspectors reviewed a random sample of 30 medical records on patients admitted for one day during FY 1999. We found that clinicians properly recorded patient care and the patients' conditions. The records also reflected that employees provided patients their prescriptions with follow-up appointments before their discharge from inpatient care, and they also provided patients appropriate education.

Peer Reviews

OHI inspectors reviewed 13 peer reviews that hospital employees conducted on tort claim cases. We found that the peer reviews were comprehensive, and that the conclusions and recommendations were consistent with the findings.

Boards of Investigation (BOI) and Root Cause Analyses

OHI Inspectors reviewed the summaries and recommendations of 15 BOIs and/or root cause analyses for events that occurred in FY 1999. The BOIs/root cause analyses were appropriately conducted on incidents that resulted in, or had the potential to cause, major patient injury, with a high probability that investigators might recommend disciplinary actions. Examples of these include death after an invasive procedure, suicide, patient abuse, and serious medication errors. The conclusions and recommendations were consistent with the investigative findings and were reported to the VISN as required.

Patient Incident Reports

We reviewed Reports of Special Inquiry Involving a Beneficiary (VA Form 10-2633) for the last three fiscal quarters of FY 1998. Employees properly reviewed all of the reported patient incidents as required by VHA policy.

Summary of Recommendations

The Medical Center Director should:

1. Continue efforts to adjust the professional mix and staffing levels of Nursing Service employees assigned to patient care areas and inpatients units.

2. Assess the adequacy of one employee on duty during a shift to staff both residential treatment wards (4 North and 4 South)

3. Assess the professional mix of primary care providers and consider increasing the number of nurse practitioners and physician assistants.

4. Assess the closure of the radiology section in the Ambulatory Care Center and provide a better mechanism for transporting patients to Radiology for x-rays and to other services they may require, including pharmacies.

5. Assess the causes of excessive waiting times for prescriptions and reduce waiting times to VHA standards.

6. Evaluate registration areas that do not ensure auditory privacy and take corrective actions.

7. Evaluate managers' uses of available awards and methods to recognize employees, to ensure equitability and to improve employee productivity and morale.

Management Control Issues

Objectives and Scope

The Office of Audit reviewed selected hospital administrative activities and management controls. The objectives of the review were to determine if the selected activities and controls operated effectively.

We reviewed the following 16 administrative activities and management controls:

Agent Cashier Operations
Ambulance Contracting
Controlled Substances Security
Certified Invoice Controls
Credentialing and Privileging of Clinicians
Decision Support System Implementation
Equipment Warehousing
Generic Inventory Package Implementation
Government Purchase Card Controls
Hazardous Materials Controls
Means Test Controls
Medical Care Collections Fund Operations
Part-time Physician Time and Attendance
Surgeon Productivity
Surgical Resident Supervision

In addition, we reviewed 10 complaints to the OIG Hotline. Two issues raised in these complaints bore no direct connection to VAH Hines and will be reported separately.

The review covered hospital operations for Fiscal Year 1998 and the first three-quarters of Fiscal Year 1999. In performing the review, we inspected work areas, interviewed hospital management and staff, and reviewed pertinent administrative, financial, and clinical records.

Results

We concluded that the administrative activities reviewed were generally operating satisfactorily and management controls were generally effective. We found no problems or only minor deficiencies in the following areas:

- **Implementation of the Generic Inventory Package.** We reviewed implementation of VA's Generic Inventory Package (GIP). GIP is an automated system used to control inventories of medical supplies. Although GIP has been available for several years, Hines staff only began implementing GIP in early 1999. In addition, as of the date of our review, they were only using it to control medical supplies for the Central Supply area. Pharmacy staff, who have operational control over Central Supply,

estimated that it might be June 2000 before GIP is fully implemented. Staff were still gaining experience with GIP, and inventory errors did occur. For example, we noted an apparent discrepancy in the number of hypodermic needles on hand in Central Supply. Investigation by Central Supply staff revealed that, in at least some cases, staff had apparently mis-recorded the unit of measure for needles dispensed to end users. Instead of recording 100 needles issued, they apparently recorded 1 box issued (each box containing 100 needles). As staff gain experience, we presume that such errors will occur less often.

- **Surgical Resident Supervision.** Reviews of operating room logs showed that supervision by attending physicians of residents performing surgical procedures complied with current agency requirements. Supervision levels were consistent with the post-graduate year levels of residents and the complexity of cases. However, we did note that supervision at "level 3"[1] during surgical procedures was nearly 20 percent of all surgeries, a level substantially higher than we typically see in VA facilities. We did not attempt to determine the significance of this fact.

- **Credentialing and Privileging of Clinicians.** We reviewed credentialing and privileging (C&P) procedures for clinicians. We reviewed a judgement sample of C&P records for ten clinicians and found that they were all complete. In the case of one practitioner, we noted that additional follow-up action to clarify information contained in the record might have been justified. While C&P staff disagreed that additional work was required and we identified no adverse impact related to the case, hospital management did ask us for the name of the practitioner in question.

- **Hazardous Materials Handling.** We reviewed controls over the handling of hazardous material such as solvents, corrosives, and radioactive waste. We found that there is an active and well functioning program to evaluate work processes involving hazardous materials, to train employees in the proper handling of such materials, and to identify and control the purchase, storage, and disposal of these materials.

- **Controls Over Ambulance Contracting.** We reviewed controls over contracting for ambulance and hired car services. Through interviews and reviews of documentation, we determined that controls to prevent overbillings by contractors were in place and functioning adequately.

- **Certified Invoice Controls.** We reviewed controls over the use of certified invoices. At the time of our review, Hines staff were making use of only one certified invoice,

[1] *Level 3 supervision of surgical residents during surgical procedures means that the supervising attending physician, although not physically present, is within 20 minutes time from the operating room should his or her presence be required.*

for a wireless pager system. Analysis of procedures used to control the receipt of materials and payments revealed no weaknesses.

Areas in Need of Improvement

Controlled Substance Controls — Unannounced Inspection Procedures, Drug Destruction Procedures, and Security Can Be Improved

We identified several conditions related to controls over controlled substances. Seven of the last twelve required monthly narcotics inspections were not conducted. The inspections that were performed provided very little detail about discrepancies found and were not reported outside of Pharmacy Service. The method by which monthly narcotics inspections were performed needed to be revised, and inspectors needed to be better trained. Destruction of drugs did not occur with sufficient frequency. Lastly, ***(b)(2)*** needed to be replaced with ***(b)(2)***.

VA hospital staff are required to conduct monthly inspections of all Schedule II, III, IV, and V drugs. The purpose is to ensure that controlled substances are properly accounted for. Inspectors must be employees who do not work in Pharmacy Service. Inspectors are required to physically count the quantities of controlled substances on hand and reconcile those quantities with perpetual inventory records. Shortages must be noted and reported to the Director, who must ensure that the shortages are investigated.

Reviews of narcotics inspection records from July 1998 through June 1999 revealed that only five of the twelve required inspections were actually performed. Staff in the director's office responsible for causing inspections agreed that inspections have not been initiated as frequently as required, but explained that it was sometimes difficult to break inspectors away from their other duties.

Reviews of reports of inspections revealed two conditions that need to be addressed. Despite having to inspect 40 drug storage areas, inspectors rarely identified discrepancies in their reports. Our experience suggests that, especially for a hospital of this size and complexity, drug accounting errors occur with far more frequency than evidenced in these inspection reports. This suggests either that inspectors need additional training or that errors (presumably minor) are explained and corrected on the spot and not reported. All errors should be reported.

We also noted that the inspection reports themselves were not transmitted outside Pharmacy Service. VA Handbook 1108.2 requires that these reports be transmitted to the hospital director so that he or she is kept abreast of error trends that may develop and can take appropriate corrective action at that level when necessary.

Interviews with pharmacy staff and reviews of past narcotics inspection reports revealed a pattern of inspection procedures that needed to be changed. Narcotics inspections generally took from 2 to 7 calendar days to complete. This was caused by inspectors not all making themselves available at the same time. This, in turn, caused two unacceptable effects. First, because some drug storage locations were not inspected until as much as 7 days after others, any element of surprise was limited. Second, because of the likely movement of controlled drugs between locations, reconciliations of drug counts among the various storage locations is made unnecessarily difficult and could provide an opportunity for undetected theft. Ideally, all drug storage areas should be inspected simultaneously, or as nearly simultaneously as possible, and should be completed as quickly as possible, preferably within a day or two.[2]

VA criteria require that outdated or otherwise unusable controlled substances be destroyed at least quarterly. Reviews of drug destruction records revealed that from May to December 1998 no destructions occurred for drugs stored in Building 228, the psychiatry building. From September 1998 to March 1999, no destruction took place for drugs stored in Building 200, the main hospital building. In addition, on July 14, 1999, we observed 28 bags of unusable controlled drugs awaiting destruction in Building 200 for which there were no inventory control records. These conditions can contribute to undetected drug loss.

Lastly, we observed that ***(b)(2)*** ……. VA criteria call for ***(b)(2)*** ……..

Conclusion. To strengthen controlled substance accountability, unannounced inspections should be conducted every month by trained inspectors, and should be conducted as close to simultaneously as possible at all locations. Reports of inspections should be complete and should be communicated to top management. To minimize the possibility of diversion, outdated drugs should be destroyed at least quarterly. Finally, ***(b)(2)*** ……. should be replaced with ***(b)(2)*** ……as soon as practical.

Equipment Accountability —Items Stored in the Warehouse Should be Distributed to Requesters as Soon as Possible

We reviewed hospital procedures for accounting for equipment shown on Consolidated Memorandums of Receipt (CMRs). Through interviews of Personal Property Management staff, we concluded that equipment accountability procedures were sound. However, we noted one related issue that needed to be addressed by hospital management. We observed a large amount of equipment and other items stored for what appeared to be an excessive period of time in the hospital warehouse.

[2] *Using the 9 Hines inspectors, we were able to complete an entire inspection, conducted as part of our CAP review, in about 16 hours (1 day and 2 half days).*

We observed a large number of computers and other computer-related equipment stored in the warehouse. Purchase order documents showed that these items were from deliveries made as long ago as September 1997 and had an original purchase value of about $808,000. However, interviews with Information Resources Management (IRM) Service officials revealed that many of the individual units represented by these purchases had been removed from the warehouse over time. At the time of our review, IRM officials and we estimated that approximately 61 laser printers, 144 computer monitors, and 75 computers remained in the warehouse. These items had a total estimated value of about $238,000. The exact numbers of units and their values was difficult to determine because many of the units were moved out of the warehouse during our review.

The Chief of IRM Service explained that he did not have sufficient staff to promptly take possession of these items upon their receipt in the warehouse and set them up for their eventual end users. Consequently, he and his staff had been doing this over an extended period of time, which left a large number of items yet to be put in service by the time of our review.

In addition to computer equipment, we identified another approximately $100,000 in long-stored items including furniture, lighting fixtures, and dialyzers intended for Medical Service. All of these items had been stored in the warehouse for at least 10 months.

Although we noted no particular physical security problems related to the storage of these items in the warehouse, we were concerned that this condition increased the risk that items may be misplaced, outdated, or stolen. In addition, the effectiveness of time sensitive manufacturer warranties and extended service contracts was impacted; thus risking additional costs for any subsequently needed repairs. When we first raised the issue of long-stored equipment in the warehouse, particularly computer equipment, with hospital management, they took immediate action to begin removing these items for eventual placement with end users.

Conclusion. To better protect valuable materials from theft and loss, and to guard against loss of warranty coverage, hospital management should ensure that equipment received in the warehouse is distributed to intended end users as quickly as possible.

Surgeon Productivity — Surgeon Productivity Was Low

We analyzed surgeon staffing and surgical workload for March 1999 and found that, in the aggregate, medical center surgeons may not have enough surgical workload to justify present staffing levels. We based this conclusion on productivity guidelines provided to us by the Deputy Director of Surgical Service in VHA Headquarters and on research

conducted on private sector surgeons and published by the American Medical Association (AMA) in "Socio-Economic Characteristics of Medical Practice."

The Deputy Director of Surgical Service in VHA has recommended that VA staff surgeons spend approximately 3/8ths (37.5 percent) of their VA time performing surgeries or supervising residents performing surgeries. This translates to 15 hours of surgery per week for a full time surgeon. The remaining 25 hours would be available for teaching, research, or other clinical duties outside the operating room and for leave. Interestingly, the AMA found that full time surgeons in the private sector generally spend a comparable amount of time in the operating room.

Our analysis of surgical workload in March 1999 showed that there were 3,349 hours of total available surgeon time provided by 18.2 FTEE staff surgeons. Based on the 3/8ths guideline, surgeons should have performed about 1,255 hours of surgery (3,349 available hours x 3/8ths). However, according to operating room logs, surgeons actually spent only 533 hours performing or supervising surgical procedures during the month, or 722 hours less than would be expected. Thus, operating room and supervision time equaled only about 16 percent of available surgeon time, which is substantially below both VHA guidelines and observed private sector practice. This left about eight FTEE surgeons[3] who appeared to be underutilized.

The 533 hours of productive operative time identified in our review for March approximated the 489 average hours per month documented by medical center staff for Fiscal Year 1998. The Chief of Surgical Service and other medical center personnel informed us that the hospital limits its surgical workload by frequently running only four or five of the nine available operating rooms because of difficulty in recruiting and retaining nurse operating room and anesthesia staff.

Conclusion: Given the budget pressures the hospital and VISN 12 are currently under, appropriate surgeon staffing is as important as staffing in every other area of the hospital. We believe that surgeon productivity and efficiency should be monitored and should be part of any future consideration of staffing adjustments.

Decision Support System (DSS) Implementation — More Staff Could Be Devoted To DSS Implementation

We concluded that staff commitment to DSS implementation and utilization is probably not sufficient to realize DSS's full potential. Presently, only two full time equivalent employees (FTEE) support DSS full time, one nurse and one person with both fiscal and

[3] *This figure does not include ophthalmologists. We excluded ophthalmologists because of their traditionally higher percentage of non-surgical duties.*

computer experience. VHA's Chief Information Office recommends a minimum DSS staffing level for a facility of Hines' size and complexity of about five FTEE.

We were concerned that only two FTEE may ultimately find it difficult to keep up with data validation and the design and production of reports for managers and clinicians, particularly as users gain more experience with DSS data in their areas of responsibility. Such difficulty would be compounded if either or both of the present staff should leave VA employment.

Our experience has shown that DSS has the potential to be an extremely valuable tool in improving clinical performance and in achieving overall medical center efficiencies. We believe, given that VISN 12 and VAH Hines are presently under pressure to reduce expenditures, being able to make informed decisions about resource utilization is essential. A fully functioning DSS would help provide middle and upper managers with the information they need to make sound decisions regarding the application of resources to hospital activities.

Conclusion. We believe hospital management needs to devote more resources to DSS implementation to better ensure the usefulness of the DSS system and, ultimately, the success of cost containment efforts.

Medical Care Collections Fund — Patient Bills Were Inaccurately Coded and Resulted in Overbillings

The Omnibus Budget Reconciliation Act of 1986 authorized the Veterans Health Administration (VHA) to collect from health insurance companies for the cost of treating insured non-service connected veterans. VHA is also authorized to bill private health insurers for health care provided to service-connected veterans for non-service connected treatments. Public Law 105-33 authorized the establishment of the Medical Care Collections Fund (MCCF), replacing the Medical Care Cost Recovery Fund. Under MCCF, all of the funds collected become part of VA's medical care budget. Annual VHA collections have grown from $23.9 million in Fiscal Year 1987 to $560 million in Fiscal Year 1998.

To determine the accuracy and validity of MCCF billings from the hospital, we reviewed a total of 60 bills generated from April 1 to June 30, 1999. Twenty of these were selected at random and were exclusively for outpatient services. All of these 20 records were properly coded for the medical services that were rendered.

We reviewed a set of 20 judgmentally selected bills to a health care insurance program. This review identified two (10 percent) where both electronic patient records and patient medical records failed to support the services coded on the billings. In one case, there was no record of the outpatient visit that was billed. In the other case, the billing was

coded as a physician consultation, when, in fact, it was performed by a nurse. Thus, health care insurance provide was overbilled by $458 for these two cases.

We reviewed a third set of 20 bills for surgical procedures performed on both inpatients and outpatients and for outpatient visits to surgical clinics. Two of these 20 bills (10 percent) did not meet Health Care Financing Administration (HCFA) standards for insurance billings, which require the presence of an attending physician during a surgical procedure. In one case, the medical record showed that a surgical procedure was performed by a resident physician without the presence of a supervising attending physician. In the other case, the record failed to identify the level of supervision provided by an attending physician although the procedure was performed by a resident. In both cases, the billings indicated that the procedures were performed by attending physicians. The potential overbilling was $3,287.

This issue of billing for surgical procedures performed by residents when an attending is not physically present will become crucial if VA adopts new surgical resident supervision rules and billing requirements, as now proposed.

Conclusion. Every overbilling creates a contingent liability that will ultimately require staff and fiscal resources to resolve. Billing staff need to ensure that bills generated for services provided to patients reflect the actual services provided.

Government Purchase Card Program — Controls over Purchase Cards Can Be Strengthened

VA medical centers are required to use commercially issued Government Purchase Cards for small purchases of goods and services (usually $2,500 or less per transaction). VHA has established controls to ensure that items purchased were actually received, charges were for official purposes, and bills were correctly paid. Cardholders must reconcile payment charges reported by the purchase card contractor with the purchase amounts recorded in the Integrated Funds Distribution, Control Point Activity, Accounting, and Procurement System within 5 days of the message confirming VA payment. Approving officials are to certify the reconciled purchase transactions within 14 days of receipt from the cardholder. Program Coordinators are to conduct periodic audits of purchase card transactions, and the Chief of Fiscal Service is required to review for accuracy monthly quality reviews conducted by the Program Coordinator. VHA purchase card policy is contained in VHA Handbook 1730.11730.1, dated August 1998.

We reviewed the timeliness of cardholder transaction reconciliations and approving official certifications of purchase card transactions occurring from December 1, 1998 through May 31, 1999. During that 6-month period, cardholders effected 6,411 transactions totaling about $4.5 million. Of those transactions, 1,142 (18 percent) were

not reconciled by cardholders within the required 5 days. Delinquent reconciliations ranged from 6 to 117 days. Of the 6,411 transactions, 557 (9 percent) had not been approved by certifying officials within the required 14 days. Delinquent approvals ranged from 16 to 111 days. In addition, we noted that 170 of the 6,411 transactions (2.7 percent) had not been approved at all by the time of our review in July 1999.

Interviews with the purchase card Program Coordinator revealed that, in her memory, no audits of credit card transactions have ever been conducted. VA policy requires that the Program Coordinator conduct periodic audits to ensure that cardholders and approving officials comply with Government Purchase Card policies and procedures.

VA policy also requires that fiscal staff conduct monthly quality reviews of selected credit card transactions to ensure that they comply with VA requirements. The particular transactions to be reviewed are selected at random by staff of VA's Financial Service Center in Austin, Texas. Our review showed that, while these quality reviews were, in fact, being conducted, the Chief of Fiscal Service was not signing the reviews to attest to their accuracy.

Our review of purchase card transactions identified a number that were for goods and services from vendors not normally associated with allowable Government Purchase Card purchases. For example, we noted purchases from airlines, hotels, restaurants, grocery stores, party goods stores, sporting goods stores, bookstores, motion picture theaters, telecommunications vendors, automobile dealerships, and finance companies, among others. VA policy for the use of Government Purchase Cards prohibits their use for such things as airline tickets, lodging, meals, entertainment, telecommunications services, and personal goods and services.

We did not attempt to validate the legitimacy of any of these transactions, but believed they deserved review by hospital management. We provided hospital management with a list of these transactions and asked that they review them for appropriateness. They were able to complete only a preliminary review prior to our departure, but were able to conclude that many were proper. For example, many of the purchases that appeared to be for food and other entertainment were in fact for patient recreation activities paid for from General Post Funds, an allowable expense for that account. Other transactions remained to be reviewed.

If further review finds that any of those purchases, or others, were not proper under VA purchase card policies, appropriate disciplinary action should be taken against purchase card holders and the respective approving officials to include, where warranted, restitution of funds.

Conclusion. To eliminate delinquent reconciliations and certification of purchase card transactions, Fiscal Service staff should monitor delinquent cardholders and approving

officials, and should work closely with individual employees to improve timeliness. If these measures do not markedly improve overall reconciliation and certification timeliness, purchase card responsibilities should be reassigned where necessary. The Program Coordinator should conduct periodic audits to ensure that cardholders comply with VA policies and procedures. The Chief of Fiscal Service should review and sign monthly quality reviews of credit card transactions. Hospital management should continue its review of the particular transactions we noted as unusual and determine whether they were proper. If not, appropriate disciplinary action should be taken against the cardholders and approving officials concerned.

Part-Time Physician Time and Attendance Controls — Controls over Physician Timekeeping Can Be Improved

We reviewed controls over time and attendance by part-time VA physicians. We selected seven physicians at random, all with less than full time VA appointments, and attempted to locate them during their duty hours. We located all seven. We also interviewed timekeepers in Medical and Surgical Services to determine what controls existed to ensure the presence of physicians during their duty hours. Both timekeepers told us that they normally have no personal knowledge of a physician's presence. Rather, they relied on the physicians themselves to complete their own timecards, which are subsequently certified by the respective service chiefs. Although we identified no impact among the seven physicians we tested, this system effectively removes timekeepers from their control function and could permit some physicians to take advantage of weakened controls.

Conclusion. Top management should ensure that controls over part-time physician time and attendance are effective.

Agent Cashier — The Amount of Loss Due To Theft Needs To Be Determined

We reviewed selected aspects of Agent Cashier operations. We caused an unannounced audit of the Agent Cashier's advance to be conducted. The audit revealed no unaccounted for funds. However, we identified two other issues related to the Agent Cashier's advance that required hospital management attention.

A theft of Agent Cashier and Personal Funds of Patients (PFOP) occurred in 1997. Financial records reviewed did not uncover any evidence to make a determination of the exact amount of the theft and the PFOP accounts from which the theft occurred. The review estimates that: approximately $5,000 may have been stolen from the Agent Cashier advance; another $2,621 may have been taken from three PFOP accounts; yet

another $8,675 may also have been taken from 2 more PFOP accounts.[4] However, efforts to date by Fiscal Service and Police staff have been unable to confirm: (1) that any funds were indeed missing from either or both of those accounts; and (2) that, if the accounts were indeed short, whether it was related to the theft incident.

Given the uncertainty of the amount of loss and its possible source from private patient funds, we believe appropriate additional actions should be taken to finally resolve this issue. If necessary, a complete audit of all PFOP accounts back to at least 1997 should be undertaken.

We also analyzed the Agent Cashier advance's turnover rate. The cash advance could be reduced by $10,000. As of July 13, 1999, the Agent Cashier's cash advance stood at $56,000. We analyzed cash advance turnover rates for the preceding 12 months. The analysis showed that the advance is too large by about $10,000, although half of that figure is represented by the still outstanding $5,000 from the 1997 theft. The advance could be reduced by $5,000 immediately and another $5,000 when the accounts receivable for the stolen funds is finally liquidated.

Conclusion. Fiscal Service staff should resume their efforts to determine the amount and sources of the 1997 theft. Additional actions may be suggested based on the results of their review and could include, if necessary, a complete audit of all PFOP accounts back to 1997. In addition, the Agent Cashier's advance can be reduced from $56,000 to $46,000.

Means Test Controls — Patient's Agreement To Pay Copayments Was Not Always Obtained

We reviewed controls over the financial means testing of patients. To determine whether VA should bill for medical services provided, non-service connected veteran patients (Category C) are required to provide information about their assets and income to VA staff. This information is collected once a year from continuing patients and upon application from new patients. It is used to determine whether Category C patients have the financial means to help defray part of the cost of their care.

A review of a judgement sample of 10 Category C cases revealed that hospital Admissions and Benefits staff collected and reviewed financial information from non-

[4] ***(b)(6)…(b)(7)(A)*** ……
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service connected patients as required. The review also showed that decisions made by Admissions and Benefits staff regarding the patients' ability to pay were correct.

However, we identified three cases where hospital staff failed to obtain a signed agreement from the patients to pay VA for any deductibles or copayments due from the care provided them. All three cases represented examples where patients had mailed their Financial Worksheets, VA Form 10-10F (rather than presenting them in person), and had failed to sign that portion of the form agreeing to pay. Information provided on the Forms 10-10F showed that, in all three cases, the patients' income or assets exceeded the mandatory thresholds and would likely have required payments to VA.

Conclusion. Before providing services to Category C patients, Admissions and Benefits staff need to obtain agreement from these patients that they will pay any deductible or copayment that may be due for the care they receive. Forms 10-10F that do not contain a signature in the payment agreement section need to be returned for signature.

Hotline Issues Evaluated

We examined 10 issues that were raised by hospital employees, Congressional interests, and other stakeholders before and during the review. (Two of these issues bore no direct connection to VAH Hines and will be reported separately.) The results of these reviews follow.

Substantiated

Nurse Anesthetist Locality Pay

Two former Hines nurse anesthetists complained that Certified Registered Nurse Anesthetist (CRNA) annual pay surveys were not performed correctly and that they were not promoted when it was appropriate to do so. Thus, they claim to have been underpaid for about 2 years prior to their resignations from VA employment.[5]

As Title 38 employees, nurse anesthetists are paid, in part, based on the Locality Pay System (LPS). LPS is a mechanism that allows VA to adjust salary rates for employees in covered positions to achieve salaries consistent with corresponding non-VA healthcare positions in the local labor market. Annual pay surveys of the local labor market are performed to determine what VA's salary rates should be.

We reviewed guidance for these surveys and records of surveys performed in 1997 and 1998, and we discussed the survey process with responsible Human Resources Management (HRM) Service staff. We concluded that HRM staff had followed VA

[5] *Both CRNAs have retained an attorney and are pursuing these issues on their own.*

guidance in performing these last two annual surveys. However, although they were conducted properly, the surveys did not include Loyola Hospital, one of Hines' main labor market competitors. This was a major point of contention in the complaint. According to HRM staff, Loyola was not included because its pay system for CRNA's was not sufficiently similar to Hines to allow a fair comparison of pay rates, and pay survey criteria does not require that specific hospitals be included.

We also reviewed procedures for granting promotions to CRNAs and assessed the timeliness of promotion actions. We reviewed available documentation, including the personnel records of the two former nurse anesthetists, and discussed the issue with HRM staff and the employees' former supervisor.

HRM staff notified the supervisor on August 20 and on October 10, 1996 that the employees were eligible for promotion to Nurse I, Level 2. However, we were not able to confirm that the supervisor submitted the necessary recommendations for promotion to the Professional Standards Board (PSB) for approval. Although we were provided with an unsigned copy of a recommendation for promotion to Nurse II dated March 1999 (over 2 years after initial eligibility), PSB records contained no evidence that any signed recommendations were ever received. In any event, these nurse anesthetists were not eligible for Nurse II positions as they had not yet served any time at Nurse I, Level 2.

The two CRNAs terminated their employment with VA in ***(b)(6)***. Even though the former supervisor maintained that the employees' performance warranted promotions, we found that the promotions did not occur because of his failure to submit the required recommendations to the PSB when the employees became eligible for promotion.

We believe the nurse anesthetists' supervisor should be provided with detailed and specific instructions in the necessary steps required to promote nursing staff under his supervision.

Unsubstantiated

Capital Improvement Projects

A complaint alleged that the VISN Director was spending funds on unnecessary capital projects at Hines, when the money could be better used for patient care.

We concluded that the various ongoing construction projects at Hines were adequately justified. Reviews of construction project files showed that the projects were undertaken to correct identified environmental and safety deficiencies, to increase staff efficiency, and to make outpatient areas more convenient for patients. In addition, the VISN Director does not have the authority to convert capital improvement funds to direct patient care use. The complaint was unfounded.

Transfer of Land to Loyola University

A complaint alleged that the "cessation (sic) of land to Loyola" indicated that the VISN Director was giving away Hines assets that could be used for the care of veterans. We discussed this with the Chief of Facility Management Service and with the VISN Director. Neither was aware of any plans that involved selling or transferring VA land to Loyola University, the nearby affiliate. The last such occurrence was the passage of a Federal law, in the early 1990's, that allowed Loyola the use of VA land for the construction of a Ronald McDonald House. While VISN management is presently exploring the possibility of leasing other unneeded land both to Loyola and to commercial interests, the purpose is to provide additional revenue to the Hines hospital. Therefore, we concluded that the allegation was unfounded.

Mismanagement of Projects

A complaint alleged that Facility Management Service (FMS) staff grossly mismanaged construction projects. We reviewed three projects that were specifically named as having been mismanaged. In one case, there were serious problems with the contractor that caused a relatively minor project to drag on for over 2 years. For a second project, planning had been complicated by a disagreement between hospital management and medical staff over the project's scope. At the time of our review, the third project was being satisfactorily completed, although construction was causing temporary inconvenience to clinical staff.

For all three projects, more skillful stewardship on the part of hospital management might have prevented or mitigated some of these problems. We found no evidence of mismanagement on the part of FMS staff.

VISN Director Involvement in Personnel Actions

A complaint alleged that the VISN Director inappropriately interfered in a proposal to change the part-time appointment of a physician from five-eighths time to seven-eighths time. We found that the VISN Director had required her approval for such a change, but we concluded that it was not inappropriate.

During the period of time in question, the VISN Director had in place a VISN-wide hiring freeze, and all requests for increases in staffing required her approval. This freeze was imposed after the hospital and the VISN lost significant amounts of funding under the VA budget allocation process. Since changing a physician's appointment from five-eighths to seven-eighths time effectively results in an FTEE increase, we concluded that the approval requirement was reasonable.

Costing of a Proposed Contract with the Illinois Department of Veterans Affairs

A complaint alleged that a Hines employee was pressured by management to change her cost calculations related to a proposed contract with the Illinois Department of Veterans Affairs (IDVA). Allegedly, the pressure was to create false cost figures, for submittal to VHA Headquarters officials, that better favored consummating the contract. The proposed agreement would turn over a portion of Hines' extended care facility to IDVA to operate as a state Veterans Home. IDVA would pay Hines a *per diem* for each patient in the home and Hines would be guaranteed a certain percentage of beds for their own patients. The complaint also alleged that the resulting cost data was derived from sources other than VA's Cost Distribution Report (CDR), contrary to VHA Headquarters requirements. The complaint raised had to do with what *per diem* rate IDVA would pay and how it was calculated.

The employee who was allegedly pressured told us that she had never been told or otherwise pressured to manipulate her cost calculations. She stated that rather than use just cost figures generated from VA's Cost Distribution Report (CDR), she based her cost analysis on figures obtained both from the CDR and from staff in the affected hospital services.

We contacted VHA Headquarters staff responsible for reviewing such contracts. They informed us that they were most interested in a cost figure that was as close to actual costs as reasonably possible and that they were not concerned with the specific methodology. Headquarters staff specifically stated that, given the acknowledged inaccuracy of CDR data, supplementing it with other data sources was appropriate. We concluded that the complaint was unfounded.

Distribution of MCCF Collections To Hines VAH

A complaint alleged that Hines does not receive back from the VISN a fair share of its Medical Care Collections Fund (MCCF) receipts. We reviewed processes used by the VISN to distribute MCCF collected funds to its various facilities. Under Public Law 105-65 and VHA Directive 98-001, VISNs, as the designated budgetary and financial entity, have the authority to control and administer MCCF funds. Thus, in effect, it is the VISN that collects MCCF funds, not the individual facilities within a VISN.

In VISN 12, ten percent of MCCF collections are automatically allowed to be retained by each facility as an incentive to pursue MCCF collections. The remainder is held or redistributed to facilities at the discretion of VISN management. Because MCCF collections are "no year" funds, VISN 12 management has elected to hold most of it to buffer an anticipated shortfall in next year's medical care budget. VISN management also expressed the opinion that because Hines serves a generally more affluent population, who are more likely to have billable insurance, it would not be unreasonable

to make some part of Hines' share of MCCF collections available to other facilities serving less affluent patients. Other similarly situated facilities in the VISN also "contribute," inline with this MCCF distribution philosophy.

We concluded that, while the complaint may be technically true, its implication that Hines is unfairly treated is unfounded.

Distribution of VERA Funds to Hines VAH

A complaint alleged that VAH Hines is not treated fairly in the VISN's distribution of medical care funds based on the Veterans Equitable Resource Allocation (VERA) methodology. The complaint alleged that the distribution method does not give Hines sufficient monetary credit for the large number of patients referred to it from other medical centers in the VISN.

We interviewed both the Director and the Chief Financial Officer of VISN 12. We were informed that VERA is, by definition, a VISN funding mechanism, not a medical center funding mechanism. In theory, at least, a VISN director has complete authority to distribute VERA funds within the VISN in any manner consistent with VISN objectives. However, VISN 12 management has opted to distribute VERA funds to its various medical centers based on each facility's actual historical and projected workload reported in VA's Integrated Planning Model, although subject to modification to reflect VISN priorities and goals. In Hines case, this workload would include any and all work Hines staff perform for patients referred from other VISN 12 facilities.

We concluded that while Hines may not receive funds based on its exact relative contribution to VISN workload, under the VERA model it does not have to. VISN management has the authority to establish facility funding levels based on the larger priorities within the VISN. The implication contained in the complaint that Hines was treated unfairly was unfounded.

Summary of Recommendations

The Medical Center Director should:

8. Direct the following actions with regard to controls over controlled substances:

   a. Conduct unannounced narcotics inspections monthly.

   b. Perform unannounced narcotics inspections as close to simultaneously as possible at all drug locations.

   c. Provide additional training to inspectors as needed.

   d. Send completed inspection reports to top management.

   e. Destroy outdated and unusable drugs at least quarterly

   f. Replace ***(b)(2)*** ·····.

9. Examine ways to better ensure that equipment received in the warehouse is distributed to intended end users promptly.

10. Monitor surgeon productivity and efficiency and include surgeon staffing in any consideration of future staff reductions.

11. Devote more staff resources to Decision Support System implementation.

12. Direct that billings to third party payees reflect the actual services provided to patients.

13. Direct the following actions with regard to Government Purchase Cards:

   a. Fiscal Service staff should monitor delinquent cardholders and approving officials.

   b. Fiscal Service staff should work closely with individual employees to improve timeliness.

   c. If overall reconciliation and certification timeliness do not markedly improve, purchase card responsibilities should be reassigned where necessary.

d. The purchase card Program Coordinator should conduct periodic audits to ensure that cardholders comply with VA policies and procedures.

e. The Chief of Fiscal Service should review and sign monthly quality reviews of credit card transactions.

g. The appropriateness of cited charges made to purchase cards should be ascertained and corrective action taken if any are found to be improper.

14. Direct that Admissions and Benefits staff obtain signed agreements from Category C patients that they will pay any deductibles or copayments that may be due for their care.

15. Ensure that controls over part-time VA physician time and attendance are effective.

16. Determine the exact amount of the theft loss that occurred in 1997 and from which PFOP accounts it came and, as soon as permitted, reimburse those accounts.

Fraud and Integrity Awareness

During the period July 12, 1999, through July 16, 1999 Special Agents assigned to the Central Field Office of Investigations conducted 6 fraud and integrity briefings at Edward Hines, Jr. Hospital. The presentations were well received by approximately 131 individuals from all services at the medical center. The briefings included a lecture, a short film presentation and question and answer opportunities. Each session lasted approximately 60 minutes.

The presentations provided a history of the Office of the Inspector General, discussions of how fraud occurs, criminal case examples, and information to assist in preventing and/or the appropriate reporting mechanisms available to report fraud. Specific case examples were used to demonstrate how administrative safeguards were circumvented.

Within the Office of the Inspector General (OIG) there are other entities devoted to different disciplines and issues. The Office of Audit conducts audits to ensure that VA is utilizing its budget and other vital resources in the most efficient manner. Some audits are scheduled reviews of designated programs and often-critical areas of operations, while other audits are conducted in response to a specific allegation. VA OIG's Office of Healthcare Inspections conducts inspections of VA's medical facilities to ensure that the quality of care provided to veterans is the highest possible. They also respond to specific allegations involving patient care.

Reporting Requirements

The attendees were strongly encouraged to report all types of fraud immediately to their direct supervisor or to the Inspector General Hotline Center at Washington DC. They were made aware of MP-1, Part 1, Chapter16 that directs the responsibility of VA employees in reporting such allegations. The OIG is heavily dependent upon VA employees to report suspected instances of fraud, waste and abuse and for this reason all contact with the VA OIG to report such instances are handled as confidential contacts.

Referrals to the Office of Investigations -Administrative Investigations Division

The Administrative Investigations Division investigates allegations of serious misconduct on the part of VA officials that are not criminal in nature. Such an example would be misuse of the Government Owned Vehicle by a senior VA official.

Referrals to the Office of Investigations - Criminal Investigations Division

Upon receiving an allegation of criminal activity, the Office of Investigations will assess the allegation and make a determination as to whether or not an official investigation will be initiated. Not all referrals are accepted. If the Office of Investigations decides to

initiate an investigation, the matter is assigned to a case agent. If the investigation substantiates criminal activity, the matter is then referred to the Department of Justice (DOJ); usually the local US Attorney's Office. DOJ then determines whether or not it will accept the matter for prosecution. Not all cases referred to DOJ by the OIG are accepted. If DOJ accepts the case, either an indictment or a criminal information follows. These two vehicles are used to formally charge an individual with a crime. Following the issuance of an indictment or information, an individual either pleads guilty or goes to trial. If a guilty plea is entered or a person has been found guilty after trial, the final step in the criminal referral process is sentencing. If the investigation only substantiates administrative wrongdoing, the matter is referred back to VA management, usually the medical center or regional office director, for action. Management, with the assistance of Human Resources and Regional Counsel will determine what administrative action, if any, to take.

Importance of Timeliness

It is important to report allegations promptly to the OIG. Many investigations rely heavily on witness testimony. The greater the time interval between the occurrence and an interview, the greater the likelihood that witnesses will not recall the event in significant detail. Over time, documentation can be misplaced or destroyed. Also, most Federal criminal statutes have a 5-year period of limitations.

Areas of Interest for the Office of investigations - Criminal Investigations Division

The Office of Investigations, Criminal Investigations Division, is responsible for conducting investigations of suspected criminal activity having some VA nexus. The range and types of investigations conducted by this office are very broad. VA is the second largest Federal department and it does a large volume of purchasing. Different types of procurement fraud include bid rigging, defective pricing, double or over billing, false claims, and violations of the Sherman Anti-Trust Act. Another area of interest is bribery of VA employees; this sometimes ties into procurement activities. Bribery of VA officials can also extend into the benefits area. Other benefits-related frauds include fiduciary fraud, compensation and pension fraud, loan origination fraud, and equity skimming. Healthcare-related crimes include homicide, theft and diversion of pharmaceuticals, illegal receipt of medical services, improper fee basis billings (medical & transportation), and conflicts of interest. Still more areas of interest include workers' compensation fraud, travel voucher fraud, and false statements by both staff and beneficiaries.

The videotape presentation covered the same basic information but was replete with real life scenarios. Attendees were provided with points of contact for VA OIG and encouraged to call and discuss any concerns regarding the applicability of bringing a particular matter to the attention of VA OIG.

Special Inquiry

A Hotline Section was established during the Hines CAP review. A total of 60 allegations of instances of mismanagement, quality of patient care, insufficient medical staff, personnel issues both general and personal, racial issues, etc. were received. All issues were resolved either through the CAP review process or through hospital management taking initiatives to correct the deficiencies. One allegation of fraud, i.e. privacy act violation was referred to the Office of Investigation via the VISN # 12 Director. An investigation was initiated under case number 9IC-078CH. The allegation was unfounded and the VISN Director has been informed.

The following allegations regarding improprieties by the Acting Chief of Staff (COS) were received via the OIG Hotline Section prior to the initiation of the Hines CAP review. The review team with the approval of Headquarters management made a determination that the allegations be referred to VHA for appropriate handling.

— Falsification of job application by COS
— Interference by VISN# 12 Director in appointment of COS
— COS hired as a consultant but paid as a physician
— Professional Standards Board improperly convened
— COS detailed outside his scope of employment but still paid as COS
— Deletion of medical executive committee minutes
— Abuse of Authority by COS

Hospital Director's Response

1. As requested, the draft Combined Assessment Program (CAP) Report of Hines VA Hospital has been reviewed. We would like to offer the following comments to your report.

2. In response to the Performance Improvement Initiatives (pg. 2, paragraph 2) it should be noted that many physicians in the acute inpatient areas have found that although retrieval of the CPRS information is easy the input process is laborious and time consuming.

3. In response to the section entitled Nurse Staffing Distribution and Mix (pg.4), please see the following information:

As of August 25, 1999, 58.58 percent of Nursing Service employees are RNs. On average, 1.41 RNs supervise each health technician, LPN and clerical staff. Also, the data in the table below demonstrates that Nursing Service has many employees who do not provide actual hands-on patient care. For example, 11.99 percent of Nursing Service employees are clerical personnel who do not provide direct care.

Distribution of Nursing Personnel from CDR
As of August 24, 1999

Positions and Title	Number of Employees (FTEE)	Percentage in Nursing Service
Administration Personnel Clerical/Escort	89.52	11.99%
LPN & HCT, NA, HT	219.72	29.43%
Registered Nurse	437.42	58.58%
Total	**746.66**	**100%**

The nursing staff at Hines is required to perform phlebotomy and EKGs. These are two services that are normally assumed by Laboratory and Cardiology Services respectively. RN staffing is not rich in this institution. The acuity/complexity of the patients as well as the number of admissions, discharges and transfers must be considered.

4. In reference to the comments describing Surgical and Anesthesia Services (pg. 5), we agree with this assessment. In addition, since the report was issued, two

more attendings have retired. This has resulted in the utilization of 5.5 ORs instead of six, as well as more calls for the remaining attendings. It has been difficult to recruit anesthesia attendings. Please note that measures were taken to address delayed, canceled and rescheduled surgical procedures. In order to still provide appropriate operative services in the summer of 1997, the operating room went to "vertical scheduling." Averaging > $5000 in nursing overtime in each two-week period. Overtime is not paid to physicians (surgeons and anesthesiologists).

5. In response to your comments regarding "Availability of Clinical Staff to Patients" (pg.5), top management is currently working to address this issue. We have begun in areas such as Nursing to benchmark with other hospitals and we are initiating this process with physician staffing. Although information has been shared with staff previously on FTEE requirements, we will continue to provide additional reports with all staff as the studies are finalized.

6. Regarding Nutrition & Food Service (pg. 6), it is true that we have lost nine Registered Dietitians without replacement. Our first priority is inpatient nutrition screening and we have the documentation to show that we assess all high priority patients within 48 hours. This documentation was shown to the JCAHO mock surveyors and to the mock survey team. In fact, the mock survey team had Lakeside/West Side call us because we were doing such a good job.

7. The causes of excessive waiting time in the pharmacy have been assessed. As indicated in your report (pg. 7), a badly needed redesign of the pharmacy will commence in the first quarter of FY 2000. That redesign will be the ultimate solution for waiting times in the pharmacy. In the interim period before a new pharmacy is constructed, Pharmacy Service has recently been given authority to recruit several additional FTEE to enable the service to be more responsive to patient demands within the limits of current physical restraints to timely service.

8. Progress continues in our efforts to address the issue of "Auditory Privacy in Registration Areas" (pg. 7) through staff reminders and construction projects (Ambulatory Care-Phases 1,2, &3 and the Emergency Department).

9. In response to the issue of outpatient Radiology Services (pg. 7) needing improvement, this comment reflected complaints to a short-term trial taking place at the time of the OIG visit. The trial consisted of concentrating the outpatient workload and referring most patients to Building 200. This short-term trial ended and there are no plans to permanently initiate this plan.

10. In response to concerns over "Professional Staff Mix" (pg. 7), top management is reviewing staffing patterns and staff mix in all areas. Additionally,

we utilized the services of a healthcare consulting team (McManus Associates, Inc.) to facilitate our review of staffing for physicians, nurses and rehabilitation therapists.

11. We recognize that staff morale (pg. 7) is a challenge, especially in light of the VISN 12 Healthcare Options study. However, we have begun an on-the-spot recognition program, employee forum recognition ceremonies, reestablished our awards team and recognized employees at quarterly staff meetings. The issue of employee awards has been reinforced to service chiefs by top management at Combined Staff meetings.

12. Our VA Waits and Delays Team has been addressing the concerns raised regarding "Access and Outpatient Care" (pg. 8). Progress continues as our reports show that since July 1999, there has been a 42% decrease in the number of calendar days until the next consultant appointment in GMC. The team is continuing to initiate measures to further reduce the backlog.

13. Staffing issues in "Long Term Care Services" (pg. 8) are being addressed as hiring is now underway for both our Long Term Care and Spinal Cord Injury areas.

14. We offer our sincere appreciation for your section entitled "Employee Questionnaire Results" (pg. 9). Continuous efforts will occur to make employees increasingly aware of how management balances staff and workload. This issue has in the past, and will continue to be, a major topic at employee forums and Combined Staff Meetings. Additionally, our ongoing performance improvement efforts will continue evaluating and streamlining our clinical and administrative processes.

15. In response to the section entitled "Physical Plant Tour" (pg. 9), it should be noted that top management recently approved additional housekeeping positions. There is a VISN signage project underway to enhance patient, visitor and employee awareness. Also, projects are planned to assure support services will be more available to patients. Simultaneously, we are reviewing what changes can be made to improve the effectiveness of our information desk.

16. In response to your comments regarding staffing on 4 North and 4 South (pg. 11), we are currently evaluating our staffing patterns in Psychiatry between inpatient and SARRTP units.

17. Hines is actively pursuing "Implementation of the Generic Inventory Package" (pg. 12). We are now beginning to establish this program with clinical

services such as surgical service, in order to fully implement the GIP hospital-wide.

18. In response to the section entitled "Surgical Resident Supervision" (pg. 13), please note there are no standards as to the percentage and there has been no nationwide reporting of supervisory levels in the VA. Hines VAH Surgical Service has a large main OR volume when compared with the other 122 surgical services in the VA at the 89th percentile in volume (#17 in volume). This does not include >15,000 operative procedures (incisions and drainage's, lasers of the eye, laryngoscopies, flexible GI endoscopies, etc.) which are done outside the operating room. Please see attached the OR/PAR October 6, 1999, report which listed the OR workload, OR staffing numbers, and supervisory numbers. (All the procedural numbers, supervisory numbers, etc., were given to the VA OIG Office of Audit at the time of the CAP. This review fails to even mention them.) See Attachment A "Staffing Statistics, OR Nurse and Anesthesia Staffing and Waiting List". All level 3 supervisory cases are reviewed by the Hines VAH Surgical Service as to the appropriateness of supervision. In most cases, these are minor procedures that can be performed by intermediate level residents with the knowledge of the attending surgeon of record.

Office of Inspector General Comment

The facility comments to the above finding question the existence of a "standard" for surgical resident supervision. In fact, we cited no such standard, although there is significant VHA guidance on the topic, some of which was written as a direct result of OIG findings in reviews of VHA surgical activities since 1990. Based on our institutional knowledge from those reviews, we stand by our observation that the incidence of "level 3" supervision at Hines is higher than we have typically seen in VA.

19. We concur with the statement concerning the adequacy of "Controls of Certified Invoices" (pg. 13), however, the certified invoice process is used extensively at this facility. Over eight hundred obligations used the certified invoice process during FY 1998, which is contrary to the statement in the review of only one being used.

Office of Inspector General Comment

In response to the above finding, the facility's comment agrees with our conclusion, but objects that in Fiscal Year 1998, the hospital had over 800 obligations that used the certified invoice process. To clarify our finding, we were looking only at certified invoices used for the purchase of equipment. At the time of the CAP review, hospital staff identified to us only the one such instance of

certified invoice use that we described in the finding. In truth, the 800+ obligations cited in the facility comments could each potentially generate up to 12 certified invoices per year, for a potential total of 9600+ such invoices. It would be impractical for either hospital or OIG staff to try to determine that actual number.

20. We will take appropriate action to expand the base of narcotic inspectors to assure timely completion (not greater than 2 days) of the inspections consistent with the OIG Recommendations "Controlled Substance Controls" (pg. 14). Additionally, in November of 1999 there will be a mandatory training session for current and new inspectors. This training will be repeated annually during the month of November. Completed narcotic inspection reports will be prepared by Pharmacy Service and submitted to the Director through the AA/COS by the 10th workday of each month. All outdated and unusable controlled drugs will be destroyed quarterly and records of such destruction will be maintained in Pharmacy Service. On October 19, 1999, a request was submitted to Facilities Management Service to ***(b)(2)***…… …… …… …… ……. .

21. In response to your comments regarding "Equipment Accountability" (pg. 15), we have already met with IRM and other appropriate services to assure immediate distribution of equipment upon receipt.

22. In response to the section entitled "Surgeon Productivity - Surgeon Productivity was Low", page 16, please note there are no "productivity guidelines" that have been published or established by the VA Surgical Service. The 37.5% noted in your report is a misquote and misinterpretation. The Acting Director, VAHQ Surgical Service, states that 3/8th's time (37.5%) was an estimate in regards to an average time for a busy university surgeon, which included the entire preoperative period. In that percentage is included; the preoperative time, the total time in the OR ("anesthesia time" not "operation time"), and the postoperative time (e.g., PAR time and speaking with family members). On the average, the difference between "anesthesia time" not "operation time" alone is approximately 45-60 minutes per case. That would mean an additional 184-245 hours to the hours listed below. What is more, the reason that ophthalmology was excluded was due to the high volume of procedures performed in the non-OR setting.

In reference to your analysis of surgical workload (3349 hours of total available surgeon time provided by 18.2 FTEE staff surgeons), we offer these comments: The following is based on the actual staffing numbers for March in the OR/PAR committee reports which are attached. While according to the footnote below, the ophthalmology cases were excluded from the analysis, the OIG must have counted the ophthalmology FTEE of 2 and 5/8's because 18.2 FTEE equals the total

surgery/anesthesia FTEE of 23.75 minus 4.75 anesthesia and 0.88 oral surgery. In short, if ophthalmology were excluded, the FTEE would be 15.6. Based on the 3/8ths guideline, surgeons should have performed about 1,255 hours of surgery (3,349 available hours x 3/8ths). Based on the correct FTEE excluding ophthalmology of 15.6, the number of hours of these calculations would be 15.6 FTEE x 23 days x 8 hours/day x 0.375 = 1076 hours (2,870 available hours x 3/8ths).

To address your comment regarding surgeons spending 533 hours performing or supervising surgical procedures during the month (722 hours less than expected), we offer additional information. According to the OR FY99 Staffing Summary, OR hours/month, "operation time", for the month of March was 699 hours. See Attachment A: Staffing Statistics, OR Nurse & Anesthesia Staffing and Waiting List. If one adds an additional hour per case to account for the preoperative time (245 cases or an additional 245 hours) the result is 699 hours in the main OR for the month of March+ 245 hours= 944 hours. This number includes ophthalmology procedures performed in the Hines VA OR. Therefore, one needs to use the 18.2 FTEE number and then 3/8ths, would be 1,255 hours (944 hours/1255 hours) *100%=75.2%. Seventy-five percent of this rough approximation of 3/8ths is a pretty good number considering that for FY99 all endoscopies (113 for General Surgery), laryngoscopies and other procedures in the ENT Clinic (985), cast placement and other procedures in orthopedic clinic (1502), and procedures (e.g. lasers) in eye clinic (469) were not included in the VA OIG's calculations. In summary, if one includes all procedures performed by the Hines VAH Surgical Service, OR and in the clinics, the time spent will exceed the 3/8ths time distribution. Such reallocation of procedural work to the ambulatory setting is more efficient and cost effective and is in concordance with VAHQ directives on ambulatory surgery.

In response to your statement regarding "Operating room and supervision time equaled only 16 percent of available surgeon time", we would offer the following change: "Thus, operating room and supervision time equaled 28% of available surgeon time, which is 75% of "3/8ths of the time in the OR." This left about eight FTEE surgeons who appeared to be underutilized. This last statement is incorrect. Please see the complete database analysis (Hines VAH Surg Workload, 48wk, 5/99) of the Hines VAH Surgery and Anesthesia Services workload as calculated for each individual section which is attached to this review. In May 1999, the Hines VAH Surgical and Anesthesia Services were staffed with 23.75 FTEE. The number of FTEE that is needed is based on actual Hines VAH surgical workload (inpatient, outpatient, OR, etc.) and is 26.59 FTEE. See Attachment B "Report of the workload of Hines Surgical and Anesthesia sections, calculated by hours".

To address your statement regarding 533 hours of productive operative time (489 average hours per month) please see response #**4**.

Office of Inspector General Comment

The facility's response on the subject of surgeon productivity requires us to comment. Our recommendation to management on this issue was "Monitor surgeon productivity and efficiency, and include surgeon staffing in any consideration of future staffing adjustments." None of the facility's comments directly address that recommendation. Instead, hospital management questions our use of a guideline that employs time surgeons spend in the operating room (OR) as a measure of surgeon productivity. We stand by our findings and our methodology, but we gladly offer the following clarifying comments.

We recognize that surgeons have duties other than performing surgery, and that is why the guideline we referenced for OR time (3/8ths) is less than half of the total time available to a 1.0 FTEE surgeon. We believe that the guideline is a viable one, in that it was recommended by the head of VHA Headquarters Surgical Service and is consistent with information published by the American Medical Association (AMA). AMA published a study which showed that for the period 1990-1995, surgeons typically spent more than 15 hours per week in surgery, which would be equivalent to the 3/8ths time cited in our report (3/8 x 40 hours = 15 hours = 37.5 percent).

Our measure of a surgeon's time in the OR was that which the circulating nurse typically records in the surgical log, i.e., the time from the initial incision to the final closure of the surgical wound. Such activities as pre- and post-anesthesia care and speaking to family members, that are cited in the facility's comments, are amply provided for in the approximately 25 hours per week of non-OR time remaining for a 1.0 FTEE surgeon.

As to the inclusion or exclusion of ophthalmologists in our calculations, we took what we considered to be a very conservative position. We did show that 18.2 FTEE surgeons (including ophthalmologists) spent a total of 533 hours in the OR for the month studied. This, indeed, equated to only 16 percent of available surgeon time, as compared to 37.5 percent cited in our guideline. The resulting finding was that approximately 10.5 FTEE surgeons appeared to be underutilized. At this point, it is important to note that we then "backed out" 2.5 FTEE ophthalmologists, leaving a final conclusion that 8.0 FTEE surgeons (10.5 – 2.5 = 8.0) appeared to be underutilized. We adopted this conservative approach because we know that ophthalmologists perform relatively fewer procedures in operating rooms, but are usually highly productive in other settings.

In addition, the facility comments seek to highlight other aspects of surgeon workload. While we acknowledge that surgeons may perform other procedures, such as endoscopies and cast placement, those activities are not traditionally considered "surgery." In this regard, we would like to point out that in our review of the surgical log for the month in question, we found that nine surgeons (comprising 2.7 FTEE and excluding ophthalmologists) spent no time in the OR.

In summary, we acknowledge hospital management's right to defend their current level of surgeon staffing. However, it should be remembered that our final conclusion and recommendation was, "… that surgeon productivity and efficiency should be monitored and should be part of any future consideration of staffing adjustments." In comments written by the Chief of Surgical Service that were not included in the hospital's response,[6] the Chief commented on the above conclusion and recommendation by saying, "This needs to be done but only if appropriate workload analysis is performed." While we disagree with the implication that our analysis was not appropriate, the OIG and the Chief of Surgical Service apparently agree on the action that needs to be taken.

23. To address your concerns in section "Decision Support System (DSS) Implementation" (pg. 17-18), our top management team is currently in the process of determining the appropriate level of staffing for this department.

24. To strengthen control over the "MCCF Patient Bills Inaccurately Coded" (pg. 18) we are in the process of establishing reasonable charges assuring accurate reimbursements. Also, we have a process in place whereby all bills are closely scrutinized to eliminate the potential for overbilling.

25. In response to comments regarding the "Government Purchase Card Program" (pg. 19), management has scrutinized the particular transactions you identified and determined they were appropriate. The Associate Director has met with our Program Coordinator and that individual provides continuous updates on delinquent reconciliations. The Program Coordinator meets with individual cardholders/services to improve accountability. Also, a refresher-training course is being planned. Fiscal Service is monitoring delinquent cardholders and approving officials. The Chief, Fiscal Service will sign monthly quality reviews of credit card transactions.

[6] ***On October 19, 1999, the Chief of Surgical Service at Hines mailed copies of his own comments to the CAP report to the Director of the OIG Hotline Division, to staff of an Illinois Congressman, and to staff of an Illinois Senator.***

26. In reference to the issue regarding part-time physician timekeeping (pg. 21), we are collaborating with our clinical services to explore other available avenues to assure the integrity of the timekeeping function. The report suggested that timekeeping for part-time physicians could be improved. Criticisms were that the timekeeper is in a remote location (14th floor) and does not see every physician regularly. The IG was impressed that all randomly selected part-time attendings were readily available. In an effort to remedy this potential problem, we intend to decentralize the timekeeping to sites more proximate to part-time physician activity. This will better ensure that timekeeping is accurate.

27. Our final analysis of the Agent Cashier's (pg. 21) shortage indicates the theft of $15,721.75 (Agent Cashier funds - $5,000.50; PFOP - $10,721.25). Of this total amount, $1,873.25 has been offset ***(b)(6)*** leaving an unpaid balance of $13,848.50.

PFOP account transactions were reviewed for the entire FY 1997. No additional discrepancies were found during the review process. Additional administrative controls have been implemented to prevent future occurrences.

The VA Austin Finance Center has currently allowed facilities to request an increase to their Agent Cashier's advance due to the uncertainty of Y2K replenishment problems. We will not be requesting an increase to our funds, but will use our excess to serve in its place. After the start of the new calendar year we will analyze our turnover rate versus funds on hand and reduce our advance accordingly.

28. The establishment of the Patient Administration & Financial Service will assure appropriate "Means Test Controls" (pg. 22). Under this new alignment all clerks will be combined under one service with cohesive lines of authority. As this new service is established, formalized training will be provided and include direction on the means test process.

29. In reference to your section entitled "Nurse Ansesthetist Locality Pay" (pg. 23), we will again provide detailed and specific instructions to the Chief, Anesthesia Service on the promotion of nursing staff. In addition, HRM stated that they did not use Loyola as an index hospital in the locality pay survey. Loyola should have been included for the following reasons:

a. Loyola is the primary affiliate of Hines.
b. Loyola is our index hospital for resident stipends.
c. Loyola has been, and continues to recruit potential Hines employees from Hines and continues to aggressively recruit FTEEs from our staff.

d. The CRNAs at Hines must take call (which they do not have to do at LUMC), see patients preoperatively (which they do not have to do at LUMC), and in general work harder and have more responsibility than the CRNAs do at LUMC).
e. Loyola and Hines are both acute tertiary care institutions.

Department of Veterans Affairs

MEMORANDUM

Date: October 14, 1999

From: Hines OR/PAR Committee & Surgical Service Chief (112)

Subj: Staffing Statistics: Resident Supervision, OR Nurse & Anesthesia Staffing and Waiting List

To: Director (00)
COS (11)
Chairman, QIT Committee (1lA)

1. Attachment #1: Attending Surgeon supervision of Surgery Residents in the OR FY-99. During the period of October 1, 1998 through September 30, 1999 (annual report for FY-99), a total of 4149 supervised procedures were documented in the OR. Of that number, attending surgery staff performed (level 0) 378 cases (9.1%); the attending surgeon was scrubbed in the OR (level 1) in 2014 cases (48.5%); the attending was in the OR suite (level 2) in cases 1023 (24.7%); the attending surgeon was immediately available (level 3) in 733 cases (17.7%); and the level of supervision was not recorded in 1 cases (0.024%). In the summations of levels 0, 1, and 2, the attending physicians were physically involved in the OR during the procedures in approximately 82.3% (3415) of the cases.

2. Attachment #2: OR Nurse and Anesthesia Staffing Report. For the period of 9/28/98 through 9/30/99 (FY-99 staffing summary), the annual totals and averages are attached: the average number of hours per room per day was 5.20 hours with the average staffing limitations of 6.45 rooms with 2852 cases being performed during this period.

Also attached is the ongoing monthly summary for September, 1999 including the total number of cases monthly performed, the number of rooms staffable by the Nursing Staff and Anesthesia Staff, the total number of hours utilized monthly in the OR, and finally the average hours per day and the average hours per room per day that were staffed during the reporting monthly. During the last monthly reporting period between 8/30/99 through 9/30/99 the average number of hours per room per day was 5.23 hours with the average staffing limitations of 5.47 rooms with 230 cases being performed during this period. (During this period, several cases were canceled or rescheduled due to a shortage of anesthesia personnel.)

3. Attachment #3: OR case workload pending. At present time, that which is attached is the pending workload of services that have been reported as

information to the Surgical Service. As of 10/5/99, there are 342 cases pending with the average scheduling time somewhere in October, 1999.

4. Attachment #4: Hines VAH Surgical Service OR/PAR Committee Meeting, September 1, 1999.

Steven DeJong, M.D., F.A.C.S.
Chairman, OR/PAR Committee

Charles H. Andrus, M.D., F.A.C.S.
Chief, Surgical Service

APPENDIX IV

Surgery Resident Supervision in OR--FY 99														
		Oct'98	**Nov'98**	**Dec'98**	**Jan'99**	**Feb'99**	**Mar'99**	**Apr'99**	**May'99**	**Jun'99**	**Jul'99**	**Aug'99**	**Sep'99**	**FY-99**
Anesthesiology	***0***	16	33	16	26	25	39	34	45	52	25	7	1	319
	1	0	0	0	0	1	0	4	3	1	1	1	0	11
	2	0	0	0	0	0	0	0	0	0	0	0	0	0
	3	0	0	0	0	0	0	0	0	0	0	0	0	0
	NR	0	0	0	0	0	0	0	0	0	0	0	0	0
	total	16	33	16	26	26	39	38	48	53	26	8	1	330
Cardiac Surgery	***0***	0	1	0	0	1	0	0	0	0	0	0	0	2
	1	5	3	1	2	4	3	4	4	4	2	3	0	35
	2	2	4	1	0	0	2	3	5	0	4	1	1	23
	3	2	3	3	5	1	2	2	0	2	1	1	3	25
	NR	0	0	0	0	0	0	0	0	0	0	0	0	0
	total	9	11	5	7	6	7	9	9	6	7	5	4	85
General Surgery	***0***	0	0	0	0	0	0	0	0	0	0	0	0	0
	1	35	37	36	26	22	43	32	31	38	29	14	39	382
	2	4	16	8	11	10	6	6	2	2	5	3	11	84
	3	10	9	11	16	20	12	20	14	2	7	11	6	138
	NR	0	0	0	0	0	0	0	0	0	0	0	0	0
	total	49	62	55	53	52	61	58	47	42	41	28	56	604
Neurosurgery	***0***	0	0	0	0	0	0	0	0	0	0	0	0	0
	1	6	9	14	8	4	12	14	11	10	7	11	13	119
	2	1	3	0	1	2	0	2	1	1	1	4	0	16
	3	4	2	3	4	2	2	3	5	2	5	2	3	37
	NR	0	0	0	0	0	0	0	0	0	0	1	0	1
	total	11	14	17	13	8	14	19	17	13	13	18	16	173

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		Oct'98	Nov'98	Dec'98	Jan'99	Feb'99	Mar'99	Apr'99	May'99	Jun'99	Jul'99	Aug'99	Sep'99	FY-99
Open Heart	0	1	0	0	1	0	0	0	0	0	0	0	0	2
	1	12	10	8	8	17	18	18	15	19	8	16	11	160
	2	0	0	0	0	0	0	1	0	0	1	0	0	2
	3	0	0	0	0	0	0	0	1	0	0	1	0	2
	NR	0	0	0	0	0	0	0	0	0	0	0	0	0
	total	13	10	8	9	17	18	19	16	19	9	17	11	166
Ophthalmology	0	6	4	4	2	2	6	4	5	2	6	6	3	50
	1	45	27	29	37	39	50	47	40	54	34	43	49	494
	2	2	3	5	3	9	11	7	3	4	0	0	1	48
	3	0	0	0	0	0	1	0	0	0	0	0	0	1
	NR	0	0	0	0	0	0	0	0	0	0	0	0	0
	total	53	34	38	42	50	68	58	48	60	40	49	53	593
Oral Surgery	0	0	0	0	0	0	0	0	0	0	0	0	2	2
	1	0	0	0	0	0	0	0	0	0	0	0	0	0
	2	0	0	0	0	0	0	0	0	0	0	0	0	0
	3	2	0	0	0	0	0	0	0	0	0	0	0	2
	NR	0	0	0	0	0	0	0	0	0	0	0	0	0
	total	2	0	0	0	0	0	0	0	0	0	0	2	4
Orthopedics	0	1	0	0	0	0	0	0	0	0	0	0	0	1
	1	14	19	15	10	9	19	16	11	14	17	16	15	175
	2	2	0	1	1	2	1	8	2	1	2	6	2	28
	3	13	6	11	18	11	17	17	15	10	5	16	11	150
	NR	0	0	0	0	0	0	0	0	0	0	0	0	0
	total	30	25	27	29	22	37	41	28	25	24	38	28	354

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		Oct'98	Nov'98	Dec'98	Jan'99	Feb'99	Mar'99	Apr'99	May'99	Jun'99	Jul'99	Aug'99	Sep'99	FY-99
Otolaryngology	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
	1	3	7	7	10	11	9	19	11	10	7	17	7	118
	2	3	0	3	2	0	2	4	1	3	1	1	4	24
	3	0	1	1	0	1	2	2	0	2	2	2	1	14
	NR	0	0	0	0	0	0	0	0	0	0	0	0	0
	total	6	8	11	12	12	13	25	12	15	10	20	12	156
Peripheral Vasc	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
	1	15	11	17	11	17	14	7	13	8	14	10	10	147
	2	0	0	0	1	1	1	1	0	2	2	3	4	15
	3	2	0	0	0	4	0	1	1	1	2	0	0	11
	NR	0	0	0	0	0	0	0	0	0	0	0	0	0
	total	17	11	17	12	22	15	9	14	11	18	13	14	173
Plastic Surgery	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
	1	3	3	2	3	3	4	5	3	5	3	2	0	36
	2	4	7	2	1	0	2	3	5	1	1	3	3	32
	3	10	4	6	2	4	3	6	3	7	0	4	4	53
	NR	0	0	0	0	0	0	0	0	0	0	0	0	0
	total	17	14	10	6	7	9	14	11	13	4	9	7	121
Podiatry	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
	1	14	9	7	20	11	9	4	3	5	12	12	5	111
	2	5	0	4	8	3	5	10	3	1	4	5	6	54
	3	2	2	1	1	1	2	2	4	1	0	1	2	19
	NR	0	0	0	0	0	0	0	0	0	0	0	0	0
	total	21	11	12	29	15	16	16	10	7	16	18	13	184

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		Oct'98	Nov'98	Dec'98	Jan'99	Feb'99	Mar'99	Apr'99	May'99	Jun'99	Jul'99	Aug'99	Sep'99	FY-99
Thoracic	0	0	0	0	0	0	0	0	1	0	0	0	0	1
	1	6	5	7	4	4	7	7	5	6	4	3	6	64
	2	1	3	0	0	0	0	0	0	0	1	1	0	6
	3	0	0	0	0	1	0	0	0	1	0	0	0	2
	NR	0	0	0	0	0	0	0	0	0	0	0	0	0
	total	7	8	7	4	5	7	7	6	7	5	4	6	73
Transplant	0	0	0	0	0	0	0	0	0	0	0	1	0	1
	1	3	8	3	3	3	10	6	6	3	2	4	4	55
	2	0	0	0	0	0	2	0	2	0	0	0	0	4
	3	3	0	1	2	3	1	1	2	1	0	3	1	18
	NR	0	0	0	0	0	0	0	0	0	0	0	0	0
	total	6	8	4	5	6	13	7	10	4	2	8	5	78
Urology-OR	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	1	12	7	5	8	6	10	7	5	2	3	5	9	79
	2	3	10	8	5	6	5	7	5	8	9	2	5	73
	3	11	5	7	9	4	4	4	6	4	6	11	4	75
	NR	0	0	0	0	0	0	0	0	0	0	0	0	0
	total	26	22	20	22	16	19	18	16	14	18	18	18	227
Urology GU Clinic 0		0	0	0	0	0	0	0	0	0	0	0	0	0
	1	1	6	1	0	1	3	9	0	0	0	3	4	28
	2	77	48	59	34	40	49	51	45	41	68	61	41	614
	3	10	15	16	12	30	38	19	12	8	11	15	0	186
	NR	0	0	0	0	0	0	0	0	0	0	0	0	0
	total	88	69	76	46	71	90	79	57	49	79	79	45	828

APPENDIX IV

OR FY99 Staffing Summary

FY-99	Oct-98	Nov-98	Dec-98	Jan-99	Feb-99	Mar-99	Apr-99	May-99	Jun-99	Jul-99	Aug-99	Sep-99	Totals & Averages
	(5 wks)	(4 wks)	(5 wks)	(4 wks)	(4 wks)	(4 wks)	(5 wks)	(4 wks)	(4 wks)	(5 wks)	(4 wks)	(5 wks)	
Total # of cases	288	218	220	229	233	245	302	239	218	225	205	230	2852
Avg # of rooms daily staffed by nursing	7.20	6.65	6.47	6.73	7.09	6.90	6.32	6.35	6.41	5.98	5.65	5.64	6.45
Avg # of rooms staffed by Anesthesia	8.04	7.31	5.98	6.78	7.38	7.45	6.76	7.10	7.01	6.13	5.80	5.47	6.77
total # of operations lasting <2 hrs	120	95	85	91	109	104	130	118	110	101	87	100	1250
total # of op lasting >2 but <4 hrs	104	78	74	96	74	94	106	77	53	77	74	83	990
total # of op lasting #>4 but <6 hrs	35	25	39	23	24	21	30	19	30	25	20	24	315
total # of op lasting #>6 hrs	29	20	22	19	26	26	36	25	25	22	24	23	297
OR hrs/month	839	614	678	646	659	699	886	644	619	633	601	653	8171
Avg # of hrs/day	34.96	34.11	33.90	34.00	34.68	34.95	35.44	32.20	32.58	30.14	30.05	28.39	32.95
Avg # of hrs/rm/ day in the month	4.85	5.08	5.79	5.11	4.94	5.11	5.62	5.07	5.05	5.03	5.48	5.23	5.20

OR FY99 Staffing Report 10/1/99

	10/2/98		**10/9/98**		**10/16/98**		**10/23/98**		**10/30/98**		**FY-99**	Oct-98
												(5 weeks)
Total # of cases	72		60		48		54		54		**Total # of cases**	288
rms nurse staff	7.8		7.2	Limiting factor is nurse staffing.	7	Limiting factor is nurse staffing.	6.8	Limiting factor is nurse staffing.	7.2	Limiting factor is nurse staffing.	**Average # of rooms daily staffed by nursing**	7.2
rms anes staff	7.8		8		8		8		8.4		**Average # of rooms daily staffed by Anesthesia**	8.04
# lasting <2 hrs	30	30.00	26	26.00	20	20.00	20	20.00	24	24.00	**total # of operations lasting <2 hrs**	120
#>2 but <4 hrs	28	84.00	20	60.00	16	48.00	22	66.00	18	54.00	**total # of op lasting >2 but <4 hrs**	104
#>4 but <6 hrs	8	40.00	7	35.00	7	35.00	7	35.00	6	30.00	**total # of op lasting #>4 but <6 hrs**	35
#>6 hrs	6	48.00	7	56.00	5	40.00	5	40.00	6	48.00	**total # of op lasting #>6 hrs**	29
	72		60		48		54		54			288
OR hrs/wk		202.00		177.00		143.00		161.00		156.00	**OR hrs/month**	839.00
# of days in wk		5.00		5.00		4.00		5.00		5.00	**Avg # of days in wk**	4.8
Avg # of hrs/day		40.40		35.40		35.75		32.20		31.20	**Avg # of hrs/day in the month**	34.96
Avg # of hrs/rm/day		5.18		4.92		5.11		4.74		4.33	**Avg # of hrs/rm/day in the month**	4.85

	11/6/98		**11/13/98**		**11/20/98**		**11/27/98**		**FY-99**	Nov-98
										(4 weeks)
Total # of cases	70		51		65		32		**Total # of cases**	218
rms nurse staff	7	Limiting factor is nurse staffing.	6.75	Limiting factor is nurse staffing.	6.6	Limiting factor is nurse staffing.	6.25	Limiting factor is nurse staffing.	**Average # of rooms daily staffed by nursing**	6.65
rms anes staff	7.6		7.5		7.4		6.75		**Average # of rooms daily staffed by Anesthesia**	7.31
# lasting <2 hrs	33	33.00	26	26.00	27	27.00	9	9.00	**total # of operations lasting <2 hrs**	95
#>2 but <4 hrs	22	66.00	16	48.00	27	81.00	13	39.00	**total # of op lasting >2 but <4 hrs**	78
#>4 but <6 hrs	10	50.00	4	20.00	7	35.00	4	20.00	**total # of op lasting #>4 but <6 hrs**	25
#>6 hrs	5	40.00	5	40.00	4	32.00	6	48.00	**total # of op lasting #>6 hrs**	20
	70		51		65		32			218
OR hrs/wk		189.00		134.00		175.00		116.00	**OR hrs/month**	614.00
# of days in wk		5.00		4.00		5.00		4.00	**Avg # of days in wk**	4.5
Avg # of hrs/day		37.80		33.50		35.00		29.00	**Avg # of hrs/day**	34.11
Avg # of hrs/rm/day		5.40		4.96		5.30		4.64	**Avg # of hrs/rm/day in the month**	5.08

APPENDIX IV

	12/4/98		12/11/98		12/18/98		12/25/98		FY-99	Dec-98
										(5 weeks)
Total # of cases	51		18		62		42		**Total # of cases**	220
rms nurse staff	7		7		6.6	Limiting factor is nurse staffing.	6.5		**Average # of rooms daily staffed by nursing**	6.47
rms anes staff	5.6	Limiting factor is anesthesia staffing.	5	Limiting factor is anesthesia staffing.	6.8		6.25	Limiting factor is anesthesia staffing.	**Average # of rooms daily staffed by Anesthesia**	5.98
# lasting <2 hrs	26	26.00	6	6.00	23	23.00	13	13.00	**total # of operations lasting <2 hrs**	85
#>2 but <4 hrs	15	45.00	9	27.00	20	60.00	13	39.00	**total # of op lasting >2 but <4 hrs**	74
#>4 but <6 hrs	5	25.00	1	5.00	13	65.00	9	45.00	**total # of op lasting #>4 but <6 hrs**	39
#>6 hrs	5	40.00	2	16.00	6	48.00	7	56.00	**total # of op lasting #>6 hrs**	22
	51		18		62		42			220
OR hrs/wk		136.00		54.00		196.00		153.00	**OR hrs/month**	678.00
# of days in wk		5.00		2.00		5.00		4.00	**Avg # of days in wk**	4
Avg # of hrs/day		27.20		27.00		39.20		38.25	**Avg # of hrs/day**	33.90
Avg # of hrs/rm/day		4.86		5.40		5.94		6.12	**Avg # of hrs/rm/day in the month**	5.79

	1/1/99		**1/8/99**		**1/15/99**		**1/22/99**		**1/29/99**		**FY-99**	Jan-99
												(4 weeks)
Total # of cases	47		54		61		53		61		**Total # of cases**	229
rms nurse staff	5.25	Limiting factor is nurse staffing.	6.8		6.6	Limiting factor is nurse staffing.	6.5		7		**Average # of rooms daily staffed by nursing**	6.725
rms anes staff	6.25		6.8		6.8		6.5		7		**Average # of rooms daily staffed by Anesthesia**	6.78
# lasting <2 hrs	17	17.00	20	20.00	28	28.00	18	18.00	25	25.00	**total # of operations lasting <2 hrs**	91
#>2 but <4 hrs	17	51.00	26	78.00	22	66.00	25	75.00	23	69.00	**total # of op lasting >2 but <4 hrs**	96
#>4 but <6 hrs	11	55.00	2	10.00	7	35.00	5	25.00	9	45.00	**total # of op lasting #>4 but <6 hrs**	23
#>6 hrs	2	16.00	6	48.00	4	32.00	5	40.00	4	32.00	**total # of op lasting #>6 hrs**	19
	47		54		61		53		61			229
OR hrs/wk		139.00		156.00		161.00		158.00		171.00	**OR hrs/month**	646.00
# of days in wk		4.00		5.00		5.00		4.00		5.00	**Avg # of days in wk**	4.6
Avg # of hrs/day		34.75		31.20		32.20		39.50		34.20	**Avg # of hrs/day**	34.00
Avg # of hrs/rm/day		6.62		4.59		4.88		6.08		4.89	**Avg # of hrs/rm/day in the month**	5.11

	2/5/99		**2/12/99**		**2/19/99**		**2/26/99**		**FY-99**	Feb-99
										(4 weeks)
Total # of cases	58		69		47		59		**Total # of cases**	233
rms nurse staff	6.4	Limiting factor is nurse staffing.	7.2		7.75		7	Limiting factor is nurse staffing.	**Average # of rooms daily staffed by nursing**	7.0875
rms anes staff	7.6		7.2		7.5	Limiting factor is anesthesia staffing.	7.2		**Average # of rooms daily staffed by Anesthesia**	7.38
# lasting <2 hrs	28	28.00	34	34.00	20	20.00	27	27.00	**total # of operations lasting <2 hrs**	109
#>2 but <4 hrs	17	51.00	20	60.00	18	54.00	19	57.00	**total # of op lasting >2 but <4 hrs**	74
#>4 but <6 hrs	6	30.00	7	35.00	3	15.00	8	40.00	**total # of op lasting #>4 but <6 hrs**	24
#>6 hrs	7	56.00	8	64.00	6	48.00	5	40.00	**total # of op lasting #>6 hrs**	26
	58		69		47		59			233
OR hrs/wk		165.00		193.00		137.00		164.00	**OR hrs/month**	659.00
# of days in wk		5.00		5.00		4.00		5.00	**Avg # of days in wk**	4.75
Avg # of hrs/day		33.00		38.60		34.25		32.80	**Avg # of hrs/day**	34.68
Avg # of hrs/rm/day		5.16		5.36		4.57		4.69	**Avg # of hrs/rm/day in the month**	4.94

APPENDIX IV

	3/5/99		**3/12/99**		**3/19/99**		**3/26/99**		**FY-99**	Mar-99
										(4 weeks)
Total # of cases	58		68		60		59		**Total # of cases**	245
rms nurse staff	6.8	Limiting factor is nurse staffing.	6.8		7	Limiting factor is nurse staffing.	7	Limiting factor is nurse staffing.	**Average # of rooms daily staffed by nursing**	6.9
rms anes staff	7.8		6.6	Limiting factor is anesthesia staffing.	8		7.4		**Average # of rooms daily staffed by Anesthesia**	7.45
# lasting <2 hrs	24	24.00	29	29.00	26	26.00	25	25.00	**total # of operations lasting <2 hrs**	104
#>2 but <4 hrs	20	60.00	29	87.00	22	66.00	23	69.00	**total # of op lasting >2 but <4 hrs**	94
#>4 but <6 hrs	5	25.00	6	30.00	6	30.00	4	20.00	**total # of op lasting #>4 but <6 hrs**	21
#>6 hrs	9	72.00	4	32.00	6	48.00	7	56.00	**total # of op lasting #>6 hrs**	26
	58		68		60		59			245
OR hrs/wk		181.00		178.00		170.00		170.00	**OR hrs/month**	699.00
# of days in wk		5.00		5.00		5.00		5.00	**Avg # of days in wk**	5
Avg # of hrs/day		36.20		35.60		34.00		34.00	**Avg # of hrs/day**	34.95
Avg # of hrs/rm/day		5.32		5.39		4.86		4.86	**Avg # of hrs/rm/day in the month**	5.11

APPENDIX IV

	4/2/99		**4/9/99**		**4/16/99**		**4/23/99**		**4/30/99**		**FY-99**	Apr-99
												(5 weeks)
Total # of cases	56		58		61		72		55		**Total # of cases**	302
rms nurse staff	6.4	Limiting factor is nurse staffing.	5.8	Limiting factor is nurse staffing.	6.4	Limiting factor is nurse staffing.	6.6	Limiting factor is nurse staffing.	6.4	Limiting factor is nurse staffing.	**Average # of rooms daily staffed by nursing**	6.32
rms anes staff	7		6.2		6.6		7		7		**Average # of rooms daily staffed by Anesthesia**	6.76
# lasting <2 hrs	27	27.00	20	20.00	24	24.00	34	34.00	25	25.00	**total # of operations lasting <2 hrs**	130
#>2 but <4 hrs	16	48.00	24	72.00	24	72.00	25	75.00	17	51.00	**total # of op lasting >2 but <4 hrs**	106
#>4 but <6 hrs	6	30.00	5	25.00	6	30.00	6	30.00	7	35.00	**total # of op lasting #>4 but <6 hrs**	30
#>6 hrs	7	56.00	9	72.00	7	56.00	7	56.00	6	48.00	**total # of op lasting #>6 hrs**	36
	56		58		61		72		55			302
OR hrs/wk		161.00		189.00		182.00		195.00		159.00	**OR hrs/month**	886.00
# of days in wk		5.00		5.00		5.00		5.00		5.00	**Avg # of days in wk**	5
Avg # of hrs/day		32.20		37.80		36.40		39.00		31.80	**Avg # of hrs/rm/day in month**	35.44
Avg # of hrs/rm/day		5.03		6.52		5.69		5.91		4.97	**Avg # of hrs/rm/day in the month**	5.62

APPENDIX IV

	5/7/99		**5/14/99**		**5/21/99**		**5/28/99**		**FY-99**	May-99
										(4 weeks)
Total # of cases	52		68		51		68		**Total # of cases**	239
rms nurse staff	6.4	Limiting factor is nurse staffing.	6.2	Limiting factor is nurse staffing.	6	Limiting factor is nurse staffing.	6.8	Limiting factor is nurse staffing.	**Average # of rooms daily staffed by nursing**	6.35
rms anes staff	7		6.8		7.2		7.4		**Average # of rooms daily staffed by Anesthesia**	7.10
# lasting <2 hrs	26	26.00	33	33.00	23	23.00	36	36.00	**total # of operations lasting <2 hrs**	118
#>2 but <4 hrs	13	39.00	26	78.00	17	51.00	21	63.00	**total # of op lasting >2 but <4 hrs**	77
#>4 but <6 hrs	8	40.00	4	20.00	3	15.00	4	20.00	**total # of op lasting #>4 but <6 hrs**	19
#>6 hrs	5	40.00	5	40.00	8	64.00	7	56.00	**total # of op lasting #>6 hrs**	25
	52		68		51		68			239
OR hrs/wk		145.00		171.00		153.00		175.00	**OR hrs/month**	644.00
# of days in wk		5.00		5.00		5.00		5.00	**Avg # of days in wk**	5
Avg # of hrs/day		29.00		34.20		30.60		35.00	**Avg # of hrs/day**	32.20
Avg # of hrs/rm/day		4.53		5.52		5.10		5.15	**Avg # of hrs/rm/day in the month**	5.07

	6/4/99		**6/11/99**		**6/18/99**		**6/25/99**		**FY-99**	Jun-99
										(4 weeks)
Total # of cases	30		73		60		55		**Total # of cases**	218
rms nurse staff	6.25	Limiting factor is nurse staffing.	6.6		6.8	Limiting factor is nurse staffing.	6	Limiting factor is nurse staffing.	**Average # of rooms daily staffed by nursing**	6.41
rms anes staff	7.25		6.6		7.4		6.8		**Average # of rooms daily staffed by Anesthesia**	7.01
# lasting <2 hrs	9	9.00	41	41.00	36	36.00	24	24.00	**total # of operations lasting <2 hrs**	110
#>2 but <4 hrs	9	27.00	17	51.00	11	33.00	16	48.00	**total # of op lasting >2 but <4 hrs**	53
#>4 but <6 hrs	7	35.00	9	45.00	6	30.00	8	40.00	**total # of op lasting #>4 but <6 hrs**	30
#>6 hrs	5	40.00	6	48.00	7	56.00	7	56.00	**total # of op lasting #>6 hrs**	25
	30		73		60		55			218
OR hrs/wk		111.00		185.00		155.00		168.00	**OR hrs/month**	619.00
# of days in wk		4.00		5.00		5.00		5.00	**Avg # of days in wk**	4.75
Avg # of hrs/day		27.75		37.00		31.00		33.60	**Avg # of hrs/day**	32.58
Avg # of hrs/rm/day		4.44		5.61		4.56		5.60	**Avg # of hrs/rm/day in the month**	5.05

	7/2/99		**7/9/99**		**7/16/99**		**7/23/99**		**7/30/99**		**FY-99**	Jul-99
												(5 weeks)
Total # of cases	42		50		55		59		19		**Total # of cases**	225
rms nurse staff	6.2		5.5	Limiting factor is nurse staffing.	6	Limiting factor is nurse staffing.	6.2		6	Limiting factor is nurse staffing.	**Average # of rooms daily staffed by nursing**	5.98
rms anes staff	6.2		5.75		6.2		6	Limiting factor is anesthesia staffing.	6.5		**Average # of rooms daily staffed by Anesthesia**	6.13
# lasting <2 hrs	21	21.00	26	26.00	23	23.00	23	23.00	8	8.00	**total # of operations lasting <2 hrs**	101
#>2 but <4 hrs	12	36.00	15	45.00	20	60.00	22	66.00	8	24.00	**total # of op lasting >2 but <4 hrs**	77
#>4 but <6 hrs	3	15.00	6	30.00	8	40.00	7	35.00	1	5.00	**total # of op lasting #>4 but <6 hrs**	25
#>6 hrs	6	48.00	3	24.00	4	32.00	7	56.00	2	16.00	**total # of op lasting #>6 hrs**	22
	42		50		55		59		19			225
OR hrs/wk		120.00		125.00		155.00		180.00		53.00	**OR hrs/month**	633.00
# of days in wk		5.00		4.00		5.00		5.00		2.00	**Avg # of days in wk**	4.2
Avg # of hrs/day		24.00		31.25		31.00		36.00		26.50	**Avg # of hrs/day**	30.14
Avg # of hrs/rm/day		3.87		5.68		5.17		6.00		4.42	**Avg # of hrs/rm/day in month**	5.03

	8/6/99		**8/13/99**		**8/20/99**		**8/27/99**		**FY-99**	Aug-99
										(4 weeks)
Total # of cases	54		53		45		53		**Total # of cases**	205
rms nurse staff	5.8	Limiting factor is nurse staffing.	5.8	Limiting factor is nurse staffing.	5.4	Limiting factor is nurse staffing.	5.6		**Average # of rooms daily staffed by nursing**	5.65
rms anes staff	6.2		6.4		5.6		5	Limiting factor is anesthesia staffing.	**Average # of rooms daily staffed by Anesthesia**	5.80
# lasting <2 hrs	23	23.00	24	24.00	18	18.00	22	22.00	**total # of operations lasting <2 hrs**	87
#>2 but <4 hrs	20	60.00	16	48.00	17	51.00	21	63.00	**total # of op lasting >2 but <4 hrs**	74
#>4 but <6 hrs	5	25.00	8	40.00	2	10.00	5	25.00	**total # of op lasting #>4 but <6 hrs**	20
#>6 hrs	6	48.00	5	40.00	8	64.00	5	40.00	**total # of op lasting #>6 hrs**	24
	54		53		45		53			205
OR hrs/wk		156.00		152.00		143.00		150.00	**OR hrs/month**	601.00
# of days in wk		5.00		5.00		5.00		5.00	**Avg # of days in wk**	5
Avg # of hrs/day		31.20		30.40		28.60		30.00	**Avg # of hrs/rm/day in the month**	30.05
Avg # of hrs/rm/day		5.38		5.24		5.30		6.00	**Avg # of hrs/rm/day in the month**	5.48

APPENDIX IV

	9/3/99		**9/10/99**		**9/17/99**		**9/24/99**		**9/30/99**		**FY-99**	Sep-99
												(5 weeks)
Total # of cases	52		39		42		50		47		**Total # of cases**	230
rms nurse staff	6		5.5		5.6		5.6	Limiting factor is nurse staffing.	5.5	Limiting factor is nurse staffing.	**Average # of rooms daily staffed by nursing**	5.64
rms anes staff	5.6	Limiting factor is anesthesia staffing.	5	Limiting factor is anesthesia staffing.	5.2	Limiting factor is anesthesia staffing.	5.8		5.75		**Average # of rooms daily staffed by Anesthesia**	5.47
# lasting <2 hrs	27	27.00	19	19.00	16	16.00	23	23.00	15	15.00	**total # of operations lasting <2 hrs**	100
#>2 but <4 hrs	14	42.00	13	39.00	17	51.00	18	54.00	21	63.00	**total # of op lasting >2 but <4 hrs**	83
#>4 but <6 hrs	6	30.00	2	10.00	6	30.00	3	15.00	7	35.00	**total # of op lasting #>4 but <6 hrs**	24
#>6 hrs	5	40.00	5	40.00	3	24.00	6	48.00	4	32.00	**total # of op lasting #>6 hrs**	23
	52		39		42		50		47			230
OR hrs/wk		139.00		108.00		121.00		140.00		145.00	**OR hrs/month**	653.00
# of days in wk		5.00		4.00		5.00		5.00		4.00	**Avg # of days in wk**	4.6
Avg # of hrs/day		27.80		27.00		24.20		28.00		36.25	**Avg # of days in wk**	28.39
Avg # of hrs/rm/day		4.96		5.40		4.65		4.83		6.30	**Avg # of hrs/rm/day in month**	5.23

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